Medical History

Patient Name:_____ **Date:**_____

Existing or Relevant Previous Conditions

Allergies	Yes	No	Dizzy Spells	Yes	No	MRSA	Yes	No
Anemia	Yes	No	Emphysema/Bronchitis	Yes	No	Multiple Sclerosis	Yes	No
Anxiety	Yes	No	Fibromyalgia	Yes	No	Muscular Disease	Yes	No
Arthritis	Yes	No	Fractures	Yes	No	Osteoporosis	Yes	No
Asthma	Yes	No	Gallbladder Problems	Yes	No	Parkinsons Disease	Yes	No
Autoimmune Disorder	Yes	No	Headaches	Yes	No	Rheumatoid Arthritis	Yes	No
Cancer	Yes	No	Hearing Impairment	Yes	No	Seizures	Yes	No
Cardiac Conditions	Yes	No	Hepatitis	Yes	No	Smoking	Yes	No
Cardiac Pacemaker	Yes	No	High Cholesterol	Yes	No	Speech Problems	Yes	No
Chemical Dependency	Yes	No	High/Low Blood Pressure	Yes	No	Strokes	Yes	No
Circulation Problems	Yes	No	HIV/AIDS	Yes	No	Thyroid Disease	Yes	No
Currently Pregnant	Yes	No	Incontinence	Yes	No	Tuberculosis	Yes	No
Depression	Yes	No	Kidney Problems	Yes	No	Vision Problems	Yes	No
Diabetes	Yes	No	Metal Implants	Yes	No			

Describe any other conditions

If "Yes" to any of the above, please explain and give approximate dates. Describe any other conditions.

_____

_____

Pain

Rate your pain since injury/surgery: **Scale of 0-10** (0 = no pain 10 = emergency)

Now:_____ Best: _____ Worst: _____

Where is the pain located?_____

What increases pain?_____

What decreases pain?_____

Have you had any diagnostic tests for your current condition (xrays, MRI, CT, Bone Scan, Surgery,etc)?

Yes No

Date of injury_____ **Date of surgery**_____

Fall History

Injury as a result of a fall in the past year? Yes No N/A

Two or more falls in the last year? Yes No N/A

Surgical History – please indicate procedure and year

_____

_____

Current Medications

No Medications taken Yes No

Medications taken for this current problem:_____

Other medications taken:

_____

_____