Patient Name:________________________________ Date:_______________

Medical History

PLEASE CHECK YES OR NO IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Alcohol / drug dependency problem			HIV / AIDS		
Allergies			Kidney Disease		
Anemia			Nervous/emotional conditions		
Bleeding disorder			Neurological conditions		
Bowel / bladder problems			Osteoarthritis		
Cancer – Date & Type / Location			Osteoporosis / osteopenia (circle)		
Choking / swallowing issues			Pacemaker or defibrillator		
Diabetes (Type I or Type II- circle)			Pregnancy		
Dizziness / nausea / vertigo (circle)			Pulmonary condition		
Fractures			Rheumatoid arthritis		
Have you had 2 or more falls in the past year?			Seizures		
Head injury			Shortness of breath / asthma		
Heart attack / heart disease (circle)			Stroke / TIA (circle)		
Heart murmur / abnormal heart beat (circle)			Thyroid problems		
Hepatitis and/or liver disease			Tuberculosis		
Hernia			Unexplained weight loss of more than 10 lbs over the past month		
High / low blood pressure (circle)					

List all surgeries or invasive procedures:

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Other medical conditions (specify specific allergies, if applicable):

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