Medical History

Patient Name: _____ **Height :** _____ **Weight:**_____

Existing or Relevant Previous Conditions. Please circle Y (yes) or N (no) to the following:

Allergies	Y	N	Dizzy Spells	Y	N	MRSA	Y	N
Anemia	Y	N	Emphysema/Bronchitis	Y	N	Multiple Sclerosis	Y	N
Anxiety	Y	N	Fibromyalgia	Y	N	Muscular Disease	Y	N
Arthritis	Y	N	Fractures	Y	N	Osteoporosis	Y	N
Asthma	Y	N	Gallbladder Problems	Y	N	Parkinson's	Y	N
Autoimmune Disorder	Y	N	Headaches	Y	N	Rheumatoid Arthritis	Y	N
Cancer	Y	N	Hearing Impairment	Y	N	Seizures	Y	N
Cardiac Conditions	Y	N	Hepatitis	Y	N	Smoking	Y	N
Cardiac Pacemaker	Y	N	High Cholesterol	Y	N	Speech Problems	Y	N
Chemical Dependency	Y	N	High/Low Blood Pressure	Y	N	Strokes	Y	N
Circulation Problems	Y	N	HIV/AIDS	Y	N	Thyroid Disease	Y	N
Currently Pregnant	Y	N	Incontinence	Y	N	Tuberculosis	Y	N
Depression	Y	N	Kidney Problems	Y	N	Vision Problems	Y	N
Diabetes	Y	N	Metal Implants	Y	N			

If "**Yes**" to any of the above, please explain in further detail here: _____

_____

_____

Anything Else we should be aware of? _____

_____

Surgical History: Please list relevant surgeries and the dates in which they took place:

_____ **date:** _____

_____ **date:** _____

_____ **date:** _____

Have you had an injury as a **result as a fall in the past year**? _____ Yes _____ No _____ N/A

Have you had **2 or more falls** in the past year? _____ Yes _____ No _____ N/A

_____ _____

Patient Signature Date