Name:	Height:	Weight:

Medical History (Please make an "X" next to all that apply)

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

Describe any other conditions below (If "Yes" to any of the above, please explain and give approximate dates/describe any other conditions.)

Fall History

Injury as a result of a fall in the past year ___ yes ___ no
Two or more falls in the last year ___ yes ___ no

Surgical History

Body Region:	Surgery Type:	Date (m/d/yyyy):
Body Region:	Surgery Type:	Date (m/d/yyyy):
Body Region:	Surgery Type:	Date (m/d/yyyy):
Body Region:	Surgery Type:	Date (m/d/yyyy):

Current Medications

Drug:	Dosage:	Frequency:	Route:	Reason Taking:
Drug:	Dosage:	Frequency:	Route:	Reason Taking:
Drug:	Dosage:	Frequency:	Route:	Reason Taking:
Drug:	Dosage:	Frequency:	Route:	Reason Taking:
Currently not taking any medications (Please make an "X" here):				

Signature _____ Date _____