



## Medical History

Patient: \_\_\_\_\_ Date: \_\_\_\_\_ Ht: \_\_\_\_\_ ft \_\_\_\_\_ in Weight: \_\_\_\_\_

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

Have you had two or more falls in the last year? YES NO  
Under Pain Management YES NO

Is this injury a result of a fall in the past year? YES NO

## Surgical History

Surgery: \_\_\_\_\_  
Surgery: \_\_\_\_\_  
Surgery: \_\_\_\_\_

Date: \_\_\_\_\_  
Date: \_\_\_\_\_  
Date: \_\_\_\_\_

## Current Medications:

Medication:	Dosage:	Frequency:	Route:	Reason for taking:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

## Pain:

**Please rate your pain on a scale of 1-10**

(1 is very mild, 5 is moderate, & 10 is very severe):

Current: \_\_\_\_\_

Worst (in past 24 hours) \_\_\_\_\_

Pain with movement: \_\_\_\_\_

**Please mark where your pain is located on the chart:**

///// is stabbing or sharp

xxx is numbness or tingling

= is burning

vvv is aching

ooo is stiffness or tightness

