Past Medical History Form **DATE:_____**

Name: _____Height:_____Weight:_____

Have you had any falls in the past year? (Medicare question only):_____

Have you ever been told you have:

	SELF		FAMILY		Do you have a history of:		
Cancer	YES	NO	YES	NO	Shortness of breath	YES	NO
High Blood Pressure	YES	NO	YES	NO	Allergies	YES	NO
Diabetes	YES	NO	YES	NO	Asthma	YES	NO
Heart Disease	YES	NO	YES	NO	Metal Implants	YES	NO
Chest pain/Angina	YES	NO	YES	NO	Polio	YES	NO
Stroke (CVA)	YES	NO	YES	NO	Emphysema	YES	NO
Kidney Disease	YES	NO	YES	NO	Do you smoke?	YES	NO
Osteoporosis	YES	NO	YES	NO	Are you pregnant?	YES	NO
Migraine Headaches	YES	NO	YES	NO	Depression	YES	NO
Chemical Dependency (alcohol/drugs)	YES	NO	YES	NO	Gout	YES	NO

Have you had recent or major surgery? YES NO

Please list current medications (with dosages):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Form has been read and review: YES NO Therapist Signature: _____Date:_____