



Past Medical History Form:

Patient Name: _____ DOB: _____

	Y	N		Y	N		Y	N
Anemia			Vertigo/dizzy			Multiple Sclerosis		
Allergies			Emphysema			Muscular Diseases		
Anxiety			Fibromyalgia			Osteoporosis		
Arthritis			Fractures			Parkinson's		
Asthma			Gallbladder problems			Rheumatoid Arthritis		
Autoimmune Disorder			Hearing impairment			Seizures		
Cancer			Hepatitis			Smoking		
Cardiac condition			High cholesterol			Speech Problems		
Cardiac pacemaker			High blood Pressure			Thyroid Disease		
Chemical Dependency			HIV/AIDS			Tuberculosis		
Circulation problems			Incontinence			Vision Problems		
Currently Pregnant			Kidney Problems			Weight /Height		
Depression			Metal Implants			One fall in the last year with injury		
Diabetes			MRSA			2 or more falls in last year		

Describe any other injury or precautions: _____

Surgical History: Body Region _____ Surgery Type _____ Date ___/___/___
 Body Region _____ Surgery Type _____ Date ___/___/___
 Body Region _____ Surgery Type _____ Date ___/___/___

Current Medications: I do not take medications Y N
 Drug: _____ Dosage _____ Reason Taking _____
 Drug: _____ Dosage _____ Reason Taking _____
 Drug: _____ Dosage _____ Reason Taking _____