Patient Name:_____ Date of Birth:_____

Primary Care Provider: _____ Height:_____ Weight:_____

Medical History

O Alzheimer's Disease

O Anemia

O Angina (Chest Pains)

O Arthritis

O Asthma

O Cancer: (type)_____

O Congestive Heart Failure

O COPD

O Crohn's Disease

O Deep Vein Thrombosis (DVT)

O Depression

O Diabetes: Type 1 or 2

O Drug Abuse (Opioid)

O High Cholesterol/Lipids

O Fibromyalgia

O Fracture: _____

O Gout

O Headache/Migraine

O Hepatitis/Liver Disease

O Hypertension (Blood Pressure)

O Inflammatory Bowel Dz

O Lyme Disease

O Myocardial Infarction (MI)

O Obesity

O Osteoporosis

O Parkinson's Disease

O Peptic Ulcer Disease

O Psoriasis

O Renal Disease= Stage:

O Scoliosis

O Seizure Disorder

O Sleep Apnea

O Spinal Stenosis

O Spondyloarthropathy

O Stroke

O Lupus (SLE)

O Thyroid Disease

O Valvular Disease

O Other:

Surgical History

O ACL repair

O Amputation

O Angioplasty

O Appendectomy (Appendix)

O Arthroscopy ("Scope")

O Back Surgery: _____

O Blood Transfusion

O CABG

O Cardiac Pacemaker

O Cardiac Valve Replacement

O Carpal Tunnel Release

O Cataract Extraction

O Cholecystectomy- Gallbladder

O Colectomy- Bowel Resection

O Colostomy

O Gastric Bypass/Lap Band

O Hernia Repair

O Hip Arthroplasty (Total Hip)

Right Left Bilateral

O Hysterectomy

O Tubal Ligation

O Knee Replacement

Right Left Bilateral

O LASIK

O Meniscus Surgery

O ORIF (Fracture Repair)

O Rotator Cuff Repair

O Small Bowel Resection

O Thyroidectomy

O Tonsillectomy

Patient Name:_____ Date of Birth:_____

Dominant Hand?	Right	Left	Ambidextrous	
Drug Allergies (List)	None	List:		
Do you use Tobacco Products or VAPE?	Never	Current	Former	**Circle What you Use:** Cigarette Cigars Snuff/Chew VAPE
Answer if EVER Smoked:	**Number of Years:**	**Packs per Day:**	**Tried to Quit?** YES NO	**Age or Year you Quit?**
Do you Drink Alcohol?	No	**Type of Drink:** Beer Wine Liquor	**Frequency:** Daily Weekly Monthly	**How many Drinks:** 1 to 2 drinks 3 to 4 drinks More than 5
Do you use Caffeine?	No	**Coffee** Cups per day:	**Soda** Drinks per day:	**Tea** Cups per Day:
Any recent changes in Sleep Pattern?	NO YES	**If YES, Please describe:**		
Do you Exercise?	No	Sedentary	Moderate	Vigorous
Are you a Member of a Health Club?	Now	Previously	Never	How often do you exercise? Daily or ___Hours per week
Please LIST your Hobbies or Activities:				
Religious Affiliation or Cultural Practices:	Do you have a religious affiliation? YES NO	Do you have Spiritual beliefs? YES NO	Religion/Denomination:	Do you agree to the use of blood or blood products? YES NO
Have you ever served in the Military?	YES NO	Branch:	Status: Active Retired	

Patient Name:_____ Date of Birth:_____

HOME & ENVIRONMENT SAFETY:

Have you fallen in the last year?	NO	YES How many times?
Did the fall result in Injury?	DETAILS:	
Are you at risk for falls?	NO	YES
Do you use a Seatbelt?	NO	YES
Smoke detectors in home?	NO	YES
Animals in Home	NO	YES
Marital Status	Divorced Married Single Widowed	
Who do you live with?	Alone Spouse Other:	
Housing Status	Own Rent Shelter Homeless	
Do you feel you have a strong support network?	NO	YES

Current Medication List:
