Health History

Name: _____ Date: _____

Approximate date of last complete medical check-up: _____

Do you have anything contagious (cold, flu, hepatitis, HIV, etc)? _____

Please mark below if you have had any of the following:

- □ Shortness of breath
- □ Pain/feeling of heaviness in chest
- □ Pulsating pain anywhere in the body
- □ Constant or severe pain in lower leg/calf
- □ Discolored or painful feet
- □ Swelling
- □ Persistent pain at night
- □ Constant pain anywhere in the body
- □ Unexplained weight loss (10-15# in 2 wks)
- □ Loss of appetite
- □ Unusual lumps or growths
- □ Fatigue
- □ Frequent or severe abdominal pain
- □ Frequent heart burn or indigestion
- □ Frequent nausea or vomiting
- □ Change/problems with bladder function; for example, urinary tract infection
- □ Change or problems with bowel function
- □ Unusual menstrual irregularities
- □ Changes in hearing
- □ Frequent or severe headaches
- □ Problems swallowing, speech changes
- □ Problems with balance or falling
- □ Fainting spells
- □ Problems with coordination
- □ Sudden weakness
- □ Fever/night sweats
- □ Recent severe emotional disturbances
- □ Swelling or redness in any joints
- □ Stress at home or work

Substance use:

- □ Caffeine use
- □ Tobacco use
- □ Alcohol use
- □ Illicit Drug use

Please list amount of substance use:

_____

Please mark if any of the following conditions apply (currently or in the past):

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

Please list surgeries: _____

Have you had a fall with injury within the past year? □ Yes □ No If so, when? _____

Have you had two or more falls within the past year? □ Yes □ No How many? _____