Today's Date: _____

Name:_____ **Date of Birth:** _____

If you are over age 65, please answer the following two questions (Circle Yes or No for each):

1. Have you had <u>two or more falls</u> in the past year? Yes No
2. Have you had <u>any</u> falls <u>with injury</u> in the past year? Yes No

Approximate Height: _____ **Weight:** _____

Medications (Please Include Doses and Over The Counter & Herbal Supplements. If additional space is needed, use the back of this form):

_____ _____

_____ _____

_____ _____

_____ _____

Allergies & Reactions:_____

_____

Do you have any of the following: ___ High Blood Pressure ___ Diabetes ___ Heart Disease ___ HIV

___ Blood Disorder – Type:_____ ___ Liver Disease - Type: _____

___ Kidney Disease - Type:_____

___ Cancer - Type:_____When?_____

<u>List any other Significant or Chronic Medical Conditions You Have</u>: _____

_____

For Female Patients: Are you Pregnant? __Yes __ No Are You Breast Feeding? ____ Yes ___ No

Surgeries (Include Reason and Approximate Dates): _____

_____

_____

_____

Hospitalizations (Include Reason and Approximate Dates): _____

_____

Do you smoke? Yes No If so, how much?_____

Do you drink alcohol? Yes No If so, how many drinks <u>per week</u>? _____

<u>Family History: Has a member of your family ever had the following:</u>

Relation:	Alive l Deceased (Circle One)	High Blood Pressure	Diabetes	Heart Disease	Stroke	Cancer (Indicate type)
Mother	**A l D**					
Father	**A l D**					
Siblings	**A l D**					
Dad's Father	**A l D**					
Dad's Mother	**A l D**					
Mom's Father	**A l D**					
Mom's Mother	**A l D**					