Existing or relevant previous conditions:

Have you ever been diagnosed as having any of the following conditions?

☐ Allergies	☐ Dizzy spells	☐ MRSA
☐ Anemia	☐ Emphysema/bronchitis	☐ Multiple Sclerosis
☐ Anxiety	☐ Fibromyalgia	☐ Muscular disease
☐ Arthritis	☐ Fractures	☐ Osteoporosis
☐ Asthma	☐ Gallbladder problems	☐ Parkinson's
☐ Autoimmune disorder	☐ Headaches	☐ Rheumatoid Arthritis
☐ Cancer	☐ Hearing Impairment	☐ Seizures
☐ Cardiac conditions	☐ Hepatitis	☐ Smoking
☐ Cardiac pacemaker	☐ High/Low blood pressure	☐ Speech problems
☐ Chemical dependency	☐ High cholesterol	☐ Stroke
☐ Circulation problems	☐ HIV/AIDS	☐ Thyroid disease
☐ Currently pregnant	☐ Incontinence	☐ Tuberculosis
☐ Depression	☐ Kidney problems	☐ Vision problems
☐ Diabetes	☐ Metal implants	

Describe any other conditions:

If "Yes" to any of the above, please explain and give approximate dates/describe other conditions:

Fall History:

☐ Injury as a result of a fall in the past year?

☐ Two or more falls in the last year?

Surgical History:

Body Region:		Surgery Type:		Date:	
Body Region:		Surgery Type:		Date:	
Body Region:		Surgery Type:		Date:	
Body Region:		Surgery Type:		Date:	

Current Medications:

Drug:		Dosage:		Frequency:		Reason Taking:	
Drug:		Dosage:		Frequency:		Reason Taking:	
Drug:		Dosage:		Frequency:		Reason Taking:	
Drug:		Dosage:		Frequency:		Reason Taking:	

☐ Current not taking any medications

Exercise:

What is your exercise routine when healthy?