General Medical History Questionnaire

Patient Name: ____ **DOB**: _______________

Do any of the following pertain to you? [Circle all that apply]

Anemia	Dizzy Spells	Parkinsons
Anxiety	Emphysema/Bronchitis	Pregnant [currently]
Arthritis	Fractures	Rheumatoid Arthritis
Asthma	Gallbladder Problems	Seizures
Cancer	Hepatitis	Speech Problems
Cardiac Conditions	High Blood Pressure	Strokes
Cardiac Pacemaker	Incontinence	Thyroid Disease
Chemical Dependency	Kidney Problems	Tuberculosis
Circulation Problems	Metal Implants	Vision Problems
Depression	Multiple Sclerosis	
Diabetes	Osteoporosis	

Do you have any allergies? Yes No

If YES, please explain. ____

Falls history:

Have you had an injury as the result of a fall in the last year? Yes No

If YES, please explain. ____

Surgical History:

Surgery type: ____ Date: ________________

Surgery type: ____ Date: ________________

Surgery type: ____ Date: ________________

Current Medications:

Drug: ____ Dose: _______________

Reason for taking: ____

Drug: ____ Dose: _______________

Reason for taking: ____

Drug: ____ Dose: _______________

Reason for taking: ____

Drug: ____ Dose: _______________

Reason for taking: ____

Drug: ____ Dose: _______________

Reason for taking: ____

Drug: ____ Dose: _______________

Reason for taking: ____

Drug: ____ Dose: _______________

Reason for taking: ____

Drug: ____ Dose: _______________

Reason for taking: ____

Are there any other conditions that we should know about?

____

____