

# Medical History



## Instructions

To determine the cause of your falls, your health care team needs details about your history, including current and past medical problems, medications, health habits, and family history.

**Name:**

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**Telephone:**

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**Past Medical History**

Have you been affected by any of the following problems or conditions? If so, when was it first found?

<b>Condition</b>	<b>When?</b>	<b>Yes</b>	<b>No</b>
Fainting or passing out	_____	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack, heart trouble	_____	<input type="checkbox"/>	<input type="checkbox"/>
Heart rhythm problem	_____	<input type="checkbox"/>	<input type="checkbox"/>
Seizure	_____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma or emphysema	_____	<input type="checkbox"/>	<input type="checkbox"/>
Excessive alcohol use	_____	<input type="checkbox"/>	<input type="checkbox"/>
Nerve damage or neuropathy	_____	<input type="checkbox"/>	<input type="checkbox"/>
Stroke or TIA's	_____	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or vertigo	_____	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	_____	<input type="checkbox"/>	<input type="checkbox"/>
Vision problems	_____	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	_____	<input type="checkbox"/>	<input type="checkbox"/>
Joint surgery	_____	<input type="checkbox"/>	<input type="checkbox"/>
Trouble holding your urine	_____	<input type="checkbox"/>	<input type="checkbox"/>
Depression	_____	<input type="checkbox"/>	<input type="checkbox"/>
Fractures	_____	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	_____	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	_____	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	_____	<input type="checkbox"/>	<input type="checkbox"/>
Vitamin D deficiency	_____	<input type="checkbox"/>	<input type="checkbox"/>

**Current  
Medical History**

Please list any current medical conditions.

**When Did It Begin?**

**Condition**

_____	_____
_____	_____
_____	_____
_____	_____

**Psychiatric  
History**

Please list all psychiatric conditions and treatments and the approximate date that it started.

**Date**

**Condition or Treatment**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you afraid of falling?

\_\_\_\_\_ No \_\_\_\_\_ Yes

Has your fear of falling limited your activities?

\_\_\_\_\_ No \_\_\_\_\_ Yes

**Family History**

Please indicate if any of your family members have had any of the following medical conditions (give the relationship to you, not the relative's name).

<b>Condition</b>	<b>Family Member(s)</b>
Arthritis	_____
Parkinson's disease	_____
Alzheimer's disease	_____
Heart disease	_____
Diabetes	_____
Depression	_____
	_____
	_____

**Health Habits**

If you currently smoke, or you have smoked in the past, please indicate the number packs per day and the number of years.

Packs per day: \_\_\_\_\_ Years: \_\_\_\_\_

If you no longer smoke, when did you quit?

\_\_\_\_\_

Do you drink alcoholic beverages on most days?

\_\_\_\_\_ No \_\_\_\_\_ Yes

If yes, how many drinks per day, usually?

(1 drink is 1 beer, 6 oz of wine, or 2 oz of hard liquor)

\_\_\_\_\_

Do you live alone?

\_\_\_\_\_ No \_\_\_\_\_ Yes

**Medication  
History**

Please list all **prescription** medicines that you currently take.

**Name of Medication**

**Dose and Times per Day**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list all **over-the-counter** medicines that you are currently taking at least once a week.

**Name of Medication**

**Dose and Frequency**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

## Review of Systems

Have you been bothered by any of the following problems in the past few months?

Please describe any problems briefly, with approximate dates. If you need more room, write on the back of the sheet. Leave the line empty if the problem has not occurred.

Problem	Description, Dates(s)
Recent acute illness	_____
Memory loss	_____
Dizziness	_____
Urinary incontinence	_____
Headache	_____
Chest pain	_____
Palpitations	_____
Joint pain	_____
Joints give way	_____
Foot problems	_____
Edema	_____
Weakness	_____
Weight loss	_____
Fatigue or tiredness	_____
Use a cane or walker	_____
Unable to dress or bathe	_____
Unable to climb stairs	_____
Unable to walk a block	_____
Sad or depressed	_____
Fear of falling limiting your activities	_____
Insomnia	_____