# Medical History

***Instructions*** To determine the cause of your falls, the doctor needs details about your history, including current and past medical problems, medications, health habits, and family history. The information may be gathered from both you and your family members.

***My name is:*** _____

***My telephone is:*** _____

***Past Medical History***

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

| Condition | When? | Yes | No |
|---|---|---|---|
| Fainting or passing out | | ☐ | ☐ |
| Heart attack, heart trouble | | ☐ | ☐ |
| Heart rhythm problem | | ☐ | ☐ |
| Seizure | | ☐ | ☐ |
| Asthma or emphysema | | ☐ | ☐ |
| Excessive alcohol use | | ☐ | ☐ |
| Nerve damage or neuropathy | | ☐ | ☐ |
| Stroke or TIA's | | ☐ | ☐ |
| Dizziness or vertigo | | ☐ | ☐ |
| Hearing loss | | ☐ | ☐ |
| Vision problems | | ☐ | ☐ |
| Arthritis | | ☐ | ☐ |
| Joint surgery | | ☐ | ☐ |
| Trouble holding your urine | | ☐ | ☐ |
| Depression | | ☐ | ☐ |
| Fractures | | ☐ | ☐ |
| Osteoporosis | | ☐ | ☐ |
| Parkinson's disease | | ☐ | ☐ |
| Kidney disease | | ☐ | ☐ |
| Vitamin D deficiency | | ☐ | ☐ |

***Current Medical History***

Please list the medical conditions currently affecting you or that you are currently receiving treatment for.

| When Did It Begin? | Condition |
|---|---|
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***Psychiatric History***

Please list all psychiatric conditions or treatments you have had, with the approximate date of onset for each.

| Date | Condition or Treatment |
|---|---|
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Are you afraid of falling?

_____ No _____ Yes

Has your fear of falling limited your activities?

_____ No _____ Yes

### *Family History*

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

| **Condition** | **Family Member(s)** |
|---|---|
| Arthritis | |
| Parkinson's disease | |
| Alzheimer's disease | |
| Heart disease | |
| Diabetes | |
| Depression | |
| | |
| | |

### *Health Habits*

If you ever smoked, how many packs per day and for how many 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 are currently taking.

| **Name of Medication** | **Strength and Times per Day** |
|---|---|
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Please list all **over-the-counter** medicines that you are currently taking at least once a week.

| **Name of Medication** | **Strength and Times per Day** |
|---|---|
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***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 limited your activities | _____ |
| Insomnia | _____ |