BIRD PHYSICAL THERAPY

Past Medical History: Have you had any of the following?

	Yes	No		Yes	No
Diabetes			Ringing in the ears		
High blood pressure			Rheumatoid Arthritis		
Heart condition(s) (chest pain/angina, heart disease, heart attacks, etc)			Concussion(s)/head trauma from car accident or otherwise		
Vascular problems (blood clots, DVTs, etc)			Change in bowel/bladder dysfunction		
Kidney problems			Hypoglycemia		
Liver/gall bladder problems			Seizures		
Smoking			Cancer		
Stroke(s)			Shortness of breath/asthmatic		
Osteoporosis/osteopenia			Emphysema/COPD		
Dizziness/fainting			Persistent night pain		
Light headedness			Frequent/severe headaches		
Excessive fatigue			Unexplained weight loss		
Recent fractures (past 10 yrs)			Severe emotional distress		
Nausea/vomiting			Prolonged steroid use		

If you stated "yes" to any of the above, please briefly explain and give approximate date:

_____

_____

_____

Is there any other information regarding your past medical history that you feel we should know about?

_____

_____

_____

Have you fallen in the past year? (circle one: yes no) If so, how many?_____ Any injuries in the fall? (circle one: yes no) Under what circumstances did you fall?_____

_____

Recent change in medications? (circle one: yes no) If so, how recent?_____

Do you have stairs in or leading up to your house? (circle one: yes no) If so, where and approximately how many?_____

Any side rails with the stairway(s)? (circle one: yes no)

Do you use any equipment for walking? (circle one: yes no) If so, please list:_____

_____

Do you have any throw rugs in your house? (circle one: yes no) If so, please list where and approximately how many:_____

_____

Any problems with the lighting in your house that you are aware of?_____

_____

Do you live alone? (circle one: yes no)