Patient Name: _____ Date: _____

Surgical Procedures:

☐ Appendectomy ☐ Caesarian Section ☐ Cardiac (angioplasty, bypass, catheterization, pacemaker, stents)
☐ Carpal Tunnel ☐ Cosmetic (_____) ☐ Dental Surgery ☐ Gall Bladder ☐ Hemorrhoids ☐ Hernia
☐ Hysterectomy (partial/ complete) ☐ Joint repair/ reconstruction (_____) ☐ Rotator Cuff (Rt/ Lt)
☐ Joint replacement (_____) ☐ Mastectomy (Rt/ Lt) ☐ OB/GYN (_____) ☐ Feet (Bunions, Spurs)
☐ Spinal (discectomy, laminectomy, fusion, rod) ☐ Sinus ☐ Tonsillectomy ☐ Tubes in Ears ☐ Tubal Ligation
☐ Vasectomy ☐ Other _____

Any falls in the past 6 months? # _____ Falls in the past year? # _____ Any injuries from falls? _____

Family History: (Conditions & Diseases)

Mother _____ Father _____
Siblings _____
Grandparents (paternal) _____
Grandparents (maternal) _____
Other _____

Children: (Names/ Ages) _____

MEDICATION LIST

MEDICATION	AMOUNT	TAKEN FOR	HOW LONG TAKEN

(INCLUDE SUPPLEMENTS AND OTC MEDICATIONS IN LIST)

MEDICATION ALLERGIES:	REACTION TO:

Signature: _____ **Date:** _____

I acknowledge that I have received a copy of the clinic's Notice of Privacy Practices for protected health information.