Patient Medical Profile

Date:	Patient Name:
Falls in the last 6 Months ☐ Yes ☐ No Details:	Hospital, ER, or Urgent Care Center Visits in the last 6 months ☐ Yes ☐ No Date: Details:

General Health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent		Activity Level: ☐ Sedentary ☐ Limited Activity ☐ Active ☐ Very Active
Height: _____ Weight: _____	Received Device within the Past Five Years: ☐ Yes ☐ No	Device Details:
Tobacco Use: ☐Currently ☐Previously ☐ Never	Has Allergies ☐ Yes ☐ No List Allergies	

Cause

☐ **Accident from Employment**	**Date:**	**State:**	**Description:**
☐ **Auto Accident**	**Date:**	**State:**	**Description:**
☐ **Other Accident**	**Date:**	**State:**	**Description:**
☐ **Condition Since Birth**			

Other Medical Conditions

☐ **Alzheimers or Dementia**	☐ **High Blood Pressure**	☐ **Osteoporosis**
☐ **Anxiety**	☐ **HIV**	☐ **Parkinson's Disease**
☐ **Asthma**	☐ **Infections**	☐ **Pulmonary Disease (TB)**
☐ **Brain Injury/TBI**	☐ **Intestinal Problems**	☐ **Rheumatoid Arthritis**
☐ **Cancer**	☐ **Kidney Disease**	☐ **Seizure Disorders**
☐ **Depression**	☐ **Liver Disease**	☐ **Skin Problems**
☐ **Diabetes Type I**	☐ **Migraines**	☐ **Stomach Problems**
☐ **Diabetes Types II**	☐ **MRSA**	☐ **Stroke/TIA/CVA**
☐ **Hearing Loss**	☐ **Neurological Problems**	☐ **Vascular Disease**
☐ **Heart Problems**	☐ **Obesity**	☐ **Vision Problems**
☐ **Hepatitis**	☐ **Osteoarthritis**	
☐ **Other Conditions**	Other Conditions	

Other Medical Conditions
Amputations:
Medication:
Surgeries:
Personal Goals for Device: