MEDICAL HISTORY

Name:____________________________DOB: ___________

Height:_______________Weight:_____________________

Physical Therapist:_________________________________

1. Please list any known allergies:____

   ____

2. Do you have a heart condition? Yes________ No________ If yes, please explain:

   ____

3. Please list current medications:____

   ____

4. Are you a diabetic? Yes_______ No________

5. Are you on insulin? Yes_______ No________ If yes, dose per day:______________________

6. Please list any medical condition(s)/surgeries we should be aware of:__________________

   ____

7. List any activities you are unable to perform relating to your condition: ________________

   ____

8. Have you received same/similar device in the past? Yes_______ No________ If yes,

   When?__________ What type of device have you received?__________________________

9. Are you currently a resident of a nursing/rehabilitation facility? Yes________No_______

   If yes, where?____

Revised: 12/17/2014, 09/14/15

Today's Date: _________________