



ORTHOPEDIC ASSOCIATES THERAPY CENTER

NAME: _____

Past Medical History

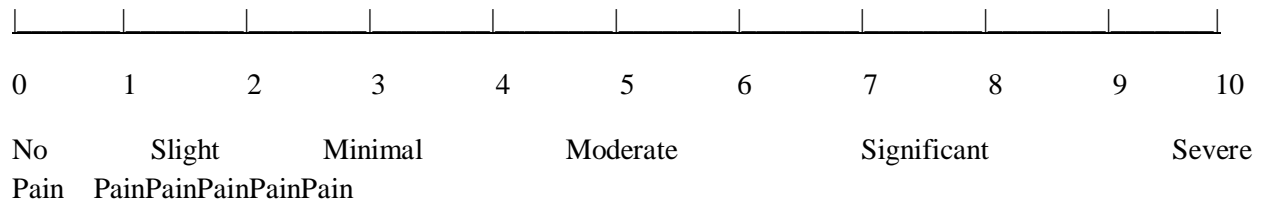
Height: _____ inches Weight: _____ lbs.

Medications (prescription and over-the-counter)

Medication Name	Dosage	Frequency	Route

*** You may also provide a previously compiled list ***

Pain



Falls

Have you fallen within the past year? Yes No If so, how many times? _____

If you have fallen, did it result in an injury? Yes No Injury: _____