## MEDICATION LIST

Patient Name: _____ Date: _____

| MEDICATION | DOSE | FREQUENCY | ROUTE OF ADMINISTRATION (circle one) |
|---|---|---|---|
| | | | oral/ injection/ patch/ sublingual |
| | | | oral/ injection/ patch/ sublingual |
| | | | oral/ injection/ patch/ sublingual |
| | | | oral/ injection/ patch/ sublingual |
| | | | oral/ injection/ patch/ sublingual |
| | | | oral/ injection/ patch/ sublingual |
| | | | oral/ injection/ patch/ sublingual |
| | | | oral/ injection/ patch/ sublingual |
| | | | oral/ injection/ patch/ sublingual |
| | | | oral/ injection/ patch/ sublingual |

## MEDICAL HISTORY

| | | | |
|---|---|---|---|
| Heart Issues | YES or NO | Cancer | YES or NO |
| Pacemaker | YES or NO | Asthma | YES or NO |
| Diabetes | YES or NO | Joint surgery | YES or NO |
| MRSA/ Staph | YES or NO | Back Surgery | YES or NO |
| Stroke/ TIA | YES or NO | Neck Surgery | YES or NO |
| Recent Falls | YES or NO | Head Injury | YES or NO |
| (Defined as 2 or more falls in the past year or any fall with injury in the past year) | | Pain Scale (If Applicable) | Worse (0-10) _____<br>Best (0-10) _____ |
| Do you use tobacco? YES or NO | | | |

Height:_____ Weight:_____

Recent MRI, CT, or X-rays concerning your visit today? YES NO

Area of body and which facility:_____

**Signature:**_____ **Date:**_____