General Medical History Form

(Please complete form in its entirety)

Name: _____ Date: _____

Date of Birth: _____ Height: _____ Weight: _____ Age: _____

What are you being evaluated for today? _____

Please explain your medical condition, the date your condition started and any medical history.

Date of injury/illness: _____

Explanation/Medical History: _____

Home Environment: House Apartment Steps/Stairs **With Whom: _____**

Please check off any of the following conditions:

Are you diabetic? YES NO Diagnosis Date: _____

Who is the doctor who treats your diabetes? _____

Alcoholism_____	Alzheimer's Disease_____	Vision Problems _____
Heart Problems_____	Hepatitis A/B/C_____	HIV_____
Hypertension_____	Kidney Disease_____	Latex Allergy_____
Multiple Sclerosis_____	Obesity_____	Parkinson's_____
Psychiatric Problems_____	Pulmonary Disease_____	Rheumatoid Arthritis__
Stroke_____	Vascular Disease_____	Other_____

List any other conditions /surgeries:

_____

Are you receiving Physical Therapy? YES NO **With Whom: _____**

Have you had the same or similar item/equipment in the past? YES NO

When and where did you get the item? _____

_____

I certify to the accuracy of the medical history provided to the company and authorize the release of any medical information necessary to justify the need for medical equipment.

_____

Patient/Guardian Signature **Date**