PATIENT CONTACT INFORMATION
Male Female
Patient's Name: PHN:
Date of Birth: Phone:
Address: City: Postal Code:
Alternate Contact Person: Phone:

PATIENT HISTORY

Major health problems (CAD, COPD, CKD, DM, Stroke, Head trauma, Neuropathy…)

Mobility
Pain
Number of falls Any fracture
Osteoporosis? Bone Mineral Density
Other

Mobility Aid: None Cane Walker Wheelchair Other

Cognition & Neurodegenerative Disease
Dementia
Parkinson’s disease
Other

Hearing

Visual (last exam)

Social history

Living status
Smoking
Drinking
Nutrition
Continence

Surgery

Medications including supplements

PHYSICAL EXAMINATION

Ht Wt BMI

Orthostatic BP

Heart and Lung exam

Ear exam

Musculoskeletal
Feet

Gait

Neurologic exam (sensory neuropathy, Cerebellar, disease, Hemiplegia …)

TUG