Patient Name: _____ DOB: _____

Reason for seeing Dr: _____ Referred By: _____

Medication List	Dose	How Taken / Frequency

*Difficulty with balance: Yes / No *Episodes with Dizziness: Yes / No *Experienced blackouts: Yes / No

Pharmacy: _____ Location: _____

Medication Allergies: _____

Surgeries: _____

Please Circle: Married / Divorced / Separated / Widowed / Single Children: Yes / No

Occupation: _____ Full Time / Part Time / Disabled / Retired

Height : _____ Weight: _____ Right Handed / Left Handed

Email Address: _____