Dresher Physical Therapy
Orthopedic • Post-Operative • Sport • Spine

MEDICARE REQUIREMENT

NAME: _____ DATE: _____

MEDICATION NAME	DOSAGE	FREQUENCY	ROUTE
*(List only medications that you are **currently** taking, such as prescriptions, over-the-counters, herbals, & nutritional supplements)*	*(Mg, ml, micrograms, grams, units, etc.)*	*(daily, hourly, weekly, etc.)*	*(Oral, sublingual, topical, injection, etc.)*

Height: _____ **Weight:** _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Have you fallen in the past year? Yes ☐ No ☐

If so, how many times? _____

Did you significantly injure yourself when you fell? Yes ☐ No ☐