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Medical History Form

Last, First, Middle | Primary Physician

Today's Date | D.O.B. & Age | Male ☐ Female ☐

Statement of Present Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Employer | Job Title

Medications: All prescription, non-prescription, vitamins, home remedies, or herbal medication

Name	**Dose** (ex: mg/pill)	**How often?**	**Date medication started**

Medication Allergies

Social History

YES	*NO*	
☐	☐	Marital Status: single ☐ married ☐ divorced ☐ widowed ☐ other ☐
☐	☐	Spouse / Partner Name:
☐	☐	Who lives at home with you?
☐	☐	Do you have an end of life directive? (Living will, medical power of attorney, etc.)
☐	☐	Tobacco Use: *(type & amount per day)* Date quit
☐	☐	Alcohol Use: (type &frequency)
☐	☐	Is alcohol a concern for you or others?
☐	☐	Caffeine Intake: None: ☐ Coffee/Tea ☐ Cups/Day Soda ☐ Cups/Day
☐	☐	Diet: (please rate) Good: ☐ Fair: ☐ Poor: ☐
☐	☐	Seat Belt Use: always ☐ occasionally ☐ never ☐
☐	☐	Are you, a relative, close friend, or companion who will be involved in your visit deaf or hard of hearing?

Current Family Health Status

Member	**Current Disease(s)**	**Health Status** *(good, fair or poor)*	**Date of Birth**	**Deceased**	**Cause of Death**
Father					
Mother					
Brother(s)					
Sister(s)					
Children					

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Patient Name:

Family Medical History

Please indicate (X) all family members* medical history *(*Mother / Father, Brother / Sister, Grandmother / Grandfather)* :

	Relationship		*Relationship*		*Relationship*
☐ Heart Disease		☐ Heart Disease		☐ Blood Disorder	
☐ High Blood Pressure		☐ High Blood Pressure		☐ Stomach Disease	
☐ Diabetes		☐ Diabetes		☐ Obesity	
☐ High Cholesterol		☐ High Cholesterol		☐ Drug/Alcohol Abuse	
☐ Stroke		☐ Stroke		☐ Mental Illness	
☐ Cancer (Incl. type)		☐ Cancer (Incl. type)		☐ Other	

PAST Personal Medical History

Immunizations and date completed:

Hepatitis A ☐ Tetanus ☐ Pneumonia ☐ Rubella ☐ Polio ☐

Hepatitis B ☐ Flu Shot ☐ Measles ☐ Varicella ☐ (chicken pox) Zostervax ☐

Travel Vaccinations:

**** Please indicate (X) and provide details for any <u>PAST</u>Medical History *(i.e. diagnosis, dates).***

☐	Surgery or Procedure	
☐	Other Hospitalizations	
☐	Transfusion	
☐	Heart problems	
☐	Blood Pressure problems	
☐	Diabetes: Type I ☐ Type II ☐	
☐	Elevated Cholesterol/Lipids	Date of last Cholesterol test & results
☐	Stroke	
☐	Cancer	
☐	EENT problems *(eye, ear, nose and throat):*	
☐	Lung problems	
☐	Gastrointestinal problems	Last colonoscopy date & results
☐	Kidney or Bladder problems	
☐	Neurologic problems	
☐	Skin problems	
☐	Bone / Muscle / Joint problems	
☐	Thyroid or other Endocrine problems	
☐	Blood Disorders	
☐	Depression / Suicide attempt or other psychiatric problems	
☐	FEMALE: Gynecological problems	
☐	Date of last Mammogram & results	Ever abnormal? Y ☐ N ☐
☐	Abnormal breast symptoms? *(describe on next page)* Y ☐ N ☐	Breast Implants? Y ☐ N ☐
☐	Date of last Pap Smear & results	Ever abnormal? Y ☐ N ☐
☐	MALE: Prostate problems / sexual dysfunction	Date of last PSA & results
☐	Other medical problems not previously mentioned	

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Patient Name: _____

CURRENT Patient Symptoms

Please indicate (X) CURRENT SYMPTOMS *(please PROVIDE **DETAILS for all "YES" answers** in space provided):*

HEAD / NECK	Headache	☐	Migraine	☐	Describe:
	Concussion Head	☐	Injury	☐	Describe:
	Seizures	☐	Dizzy spells	☐	Details:
	Fainting Light	☐	Headedness	☐	Details:
	Loss of Memory	☐		☐	Details:
	Visual problems: Glasses	☐	Contacts	☐	Details:
	Blind in either eye: Right	☐	Left	☐	Etiology / cause:
	Color blind	☐	Double Vision	☐	Details:
	Hearing Difficulties: Loss	☐	Ringing / tinnitus	☐	Details:
	Hearing Aid: Right	☐	Left	☐	Details:
	Environmental allergies	☐	Skin Allergies	☐	Describe:
	Sinus congestion	☐	Allergy related symptoms	☐	Describe:
	Mouth: Poor Teeth	☐	Toothaches	☐	Describe:
	Bleeding Gums	☐	Mouth Sores	☐	Describe:
	Oral Hot / Cold Intolerance	☐		☐	Etiology / cause:
CHEST	Chest Pain / Discomfort	☐	Palpitations	☐	Describe:
	Shortness of Breath - At rest	☐	With exercise	☐	Describe:
	Cough	☐	Cough up blood	☐	Details:
	Wheeze	☐	Associated with activity	☐	What activity?
	Breast lump or pain	☐	Nipple discharge	☐	Details:
THROAT	Swollen Glands	☐	Difficulty Swallowing	☐	Details:
GASTROINTESTINAL	Nausea	☐	Vomiting	☐	Etiology:
	Diarrhea	☐	Constipation Frequency:	☐	
	Change in Bowel Habits	☐	Longer than 1 week	☐	Details:
	Abdominal Pain	☐	Hernia	☐	Describe:
	Hemorrhoids - Internal	☐	Hemorrhoids - External	☐	Details:
	Bloody or tarry stools	☐	Frequency:	☐	Associated with hard stools?
URINARY	Burning with urination	☐	Frequency of urination	☐	Frequency:
	Urinary Incontinence	☐	Difficulty starting stream	☐	Frequency:
	Increased urination at night	☐	Inability to empty bladder	☐	Frequency:
MUSCULOSKELETAL	Muscle / joint pain	☐	Muscle / joint stiffness	☐	Location:
	Fracture or broken bone	☐	Limitation in motion	☐	Location:
	Numbness or Tingling	☐	Weakness	☐	Location:
SKIN	Rash	☐	Mole / Skin Lesion	☐	Location:
	Bruise / Bleed easily	☐	Unexplained Lumps	☐	Location:
OTHER	Unexplained weight loss	☐	Unexplained weight gain	☐	Number of pounds:
	Excessive thirst	☐	Night sweats	☐	Frequency:
	Change in energy level	☐	Weakness	☐	Details:
	Fever / chills	☐	Mood swings	☐	Describe:
	Anxiety	☐	Depression	☐	Describe:
	Insomnia - can't fall asleep	☐	Inability to stay asleep	☐	Treatment:
	Snoring	☐	Does snoring wake you?	☐	Frequency:
	Daytime sleepiness	☐	Are you told you stop breathing for periods of time when asleep?		
	Are you sexually active? Y ☐ N ☐ Method of Birth Control: Sexual Concerns:				
	FEMALES: Date of last menstrual period: Unusual vaginal bleeding Y ☐ N ☐ Are you pregnant? Y ☐ N ☐				
	MALES: Prostate Problems Y ☐ N ☐				

Please provide any other information you feel your physician should be aware of:

This information is accurate and complete to the best of my knowledge.

Patient Signature: _____ Date: _____

Reviewer Name and Signature: _____

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Exercise Program Assessment

Patient Name: _____

Date: _____

Staff Use

Body Fat% _____ **Ht** _____

Abd Girth _____ **Wt** _____

CARDIO

(check all that apply)	Time (min)	Frequency (per wk)	Intensity		
☐ Jog			☐ Low	☐ Med	☐ High
☐ Walk			☐ Low	☐ Med	☐ High
☐ Run			☐ Low	☐ Med	☐ High
☐ Bike (Stationary)			☐ Low	☐ Med	☐ High
☐ Bike (Outside)			☐ Low	☐ Med	☐ High
☐ Elliptical			☐ Low	☐ Med	☐ High
☐ Stair			☐ Low	☐ Med	☐ High
☐ Swim			☐ Low	☐ Med	☐ High
☐ Cross Country Ski			☐ Low	☐ Med	☐ High
☐ Aerobic Class			☐ Low	☐ Med	☐ High
☐ Row			☐ Low	☐ Med	☐ High

Other _____ _____ _____ ☐ Low ☐ Med ☐ High

STRENGTH	Resistance /weight	# reps / set	# sets	Frequency (per week)
☐ Chest				
☐ Upper Back				
☐ Lower Back				
☐ Shoulders (Deltoids)				
☐ Triceps				
☐ Eliceps				
☐ Forearms				
☐ Mid-Section				
☐ Hips				
☐ Quadriceps				
☐ Hamstrings				
☐ Calves				

STRETCHING/ FLEXIBILITY	Frequency (per week)	Time held per stretch	# stretches/ set
☐ Chest			
☐ Upper Back			
☐ Lower Back			
☐ Shoulders (Deltoids)			
☐ Triceps			
☐ Biceps			

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Exercise Program Assessment

Patient Name:

Date:

Gym Member?

Gym equipment @ home/work

Do you currently work with a personal trainer? Yes ☐ No ☐ If yes, frequency:

Injuries/Restrictions

FITNESS GOALS

- ☐ Increase strength/endurance
- ☐ Stress management
- ☐ Disease Management Type _____
- ☐ Race Event Type _____
- ☐ Other Type _____

Barriers to exercise:

Additional information you wish to share: