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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 PASTMedical 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 ☐ Sexual Concerns:		Method of Birth Control:		
	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: ______

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