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PATIENT MEDICAL HISTORY AND PERSONAL FITNESS QUESTIONNAIRE

The following questionnaire is used to gather information regarding your current and past medical status. Responses to these questions will provide our staff with information required to help determine the safest and most effective treatment for you.

PERSONAL HISTORY

Check each as it applies to you. Have you ever had:

T.B.	yes ___ no ___ unsure ___	Allergy	yes ___ no ___ unsure ___
Heart attack	yes ___ no ___ unsure ___	Convulsions	yes ___ no ___ unsure ___
Angina	yes ___ no ___ unsure ___	Paralysis	yes ___ no ___ unsure ___
EKG abnormalities	yes ___ no ___ unsure ___	Leg cramps	yes ___ no ___ unsure ___
Emphysema	yes ___ no ___ unsure ___	Headache	yes ___ no ___ unsure ___
High blood pressure	yes ___ no ___ unsure ___	Depression	yes ___ no ___ unsure ___
Surgery	yes ___ no ___ unsure ___	Shortness of breath	yes ___ no ___ unsure ___
Diabetes	yes ___ no ___ unsure ___	Arm Pain	yes ___ no ___ unsure ___
Stroke	yes ___ no ___ unsure ___	Low blood pressure	yes ___ no ___ unsure ___
Severe illness	yes ___ no ___ unsure ___	Indigestion	yes ___ no ___ unsure ___
Hospitalized	yes ___ no ___ unsure ___	Ulcers	yes ___ no ___ unsure ___
Blackouts	yes ___ no ___ unsure ___	Asthma	yes ___ no ___ unsure ___
Gout	yes ___ no ___ unsure ___	Hernia	yes ___ no ___ unsure ___
Nervousness	yes ___ no ___ unsure ___	Back pain	yes ___ no ___ unsure ___
Joint problems	yes ___ no ___ unsure ___	Chest pain	yes ___ no ___ unsure ___
Sleep interference	yes ___ no ___ unsure ___	Cancer	yes ___ no ___ unsure ___

Have you ever had physical therapy or currently receiving **home health**? yes ___ no ___

If so, please explain: _____

Have you ever had any orthopedic injuries, i.e. sprains, strains, fractures, etc.? yes ___ no ___

If so, please explain: _____

Have you ever had surgery? yes ___ no ___ If so, what for? _____

Any other medical problems? If so, please describe: _____

COMMENTS: _____

MEDICAL HISTORY

Name of your family physician _____

Date of last physical _____

Do you wear a pacemaker? yes ___ no ___

Do you know your resting blood pressure yes ___ no ___ _____ mmHg

Do you know your resting heart rate? yes ___ no ___ _____ BPM

Have you ever had an exercise ECG? yes ___ no ___

Are you pregnant? yes ___ no ___

Indicate any medications you are taking: _____

Please list all drug allergies: _____

I certify that to the best of my knowledge the above answers are true and correct.

Signature

Printed Name