EXOS Physical Therapy & Sports Medicine
Medical History

Name: _____ Date :_____

Date of Last Physical: _____ Age:_____ DOB: _____

Please fill out the following health information honestly and thoroughly, to the best of your knowledge. Do you now, or have you in the past, had any of the following (please also consider during and/or after exercise):

Anemia	□Yes □ No	Hypoglycemia	□ Yes □ No
AIDS/HIV	□ Yes □ No	Kidney/Bladder Infections	□ Yes □ No
Allergies	□ Yes □ No	Kidney Stones	□ Yes □ No
Anorexia/Bulimia	□ Yes □ No	Kidney Disease/Problems	□ Yes □ No
Arthritis	□ Yes □ No	Liver Disease/Problems	□ Yes □ No
Asthma	□ Yes □ No	Menstrual Irregularities	□ Yes □ No
Blood Disorder	□ Yes □ No	Metal Implants	□ Yes □ No
Blood Transfusion	□ Yes □ No	Migraines	□ Yes □ No
Cancer	□ Yes □ No	Mononucleosis	□ Yes □ No
Chest Pain/Angina	□ Yes □ No	Muscle/Joint Injury	□ Yes □ No
Cholesterol Elevation	□ Yes □ No	Nausea/Vomiting	□ Yes □ No
Chronic Bronchitis	□ Yes □ No	Neurological Disorders	□ Yes □ No
Bowel/Bladder Dysfunction	□ Yes □ No	Numbness/Tingling	□ Yes □ No
Concussion	□ Yes □ No	Osteoarthritis	□ Yes □ No
Deafness/Hearing Problem	□ Yes □ No	Osteoporosis	□ Yes □ No
Depression	□ Yes □ No	Pacemaker	□ Yes □ No
Diabetes	□ Yes □ No	Prostate Trouble	□ Yes □ No
Digestive Problems	□ Yes □ No	Phlebitis	□ Yes □ No
Dizziness/Fainting	□ Yes □ No	Respiratory Issues	□ Yes □ No
Epilepsy/Seizures	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Fatigue	□ Yes □ No	Rheumatoid Arthritis	□ Yes □ No
Fractures	□ Yes □ No	Ringing in your Ears	□ Yes □ No
Headache	□Yes □ No	Sickle Cell	□ Yes □ No
Heart Attack	□ Yes □ No	Skin Disease/Abnormalities	□ Yes □ No
Heart Disease	□ Yes □ No	Smoking	□ Yes □ No
Heart Murmur	□ Yes □ No	Stroke	□ Yes □ No
Heart Palpitations	□ Yes □ No	Surgeries	□ Yes □ No
Heart Related Illness	□ Yes □ No	Thyroid conditions	□ Yes □ No
Hepatitis	□ Yes □ No	Tuberculosis	□ Yes □ No
Hernia	□ Yes □ No	Ulcers	□ Yes □ No
High Blood Pressure	□ Yes □ No	Vision Problems	□ Yes □ No

Please list any other health issues that have affected you in the past, or are currently affecting you, that were not listed above:

_____

_____

Have you gained OR lost a significant amount of weight in the last year? □ Yes □ No
If YES, please explain:

_____

_____

During the past month have you been feeling down, depressed, or hopeless? □ Yes □ No
During the past month have you been bothered by having little interest or pleasure doing things? □ Yes □ No
Have you been diagnosed with any cardiac-related problems? □ Yes □ No

Have you had an injury before? □ Yes □ No
Have you ever had surgery? □ Yes □ No
If YES to either of the above, please describe below:

_____

_____

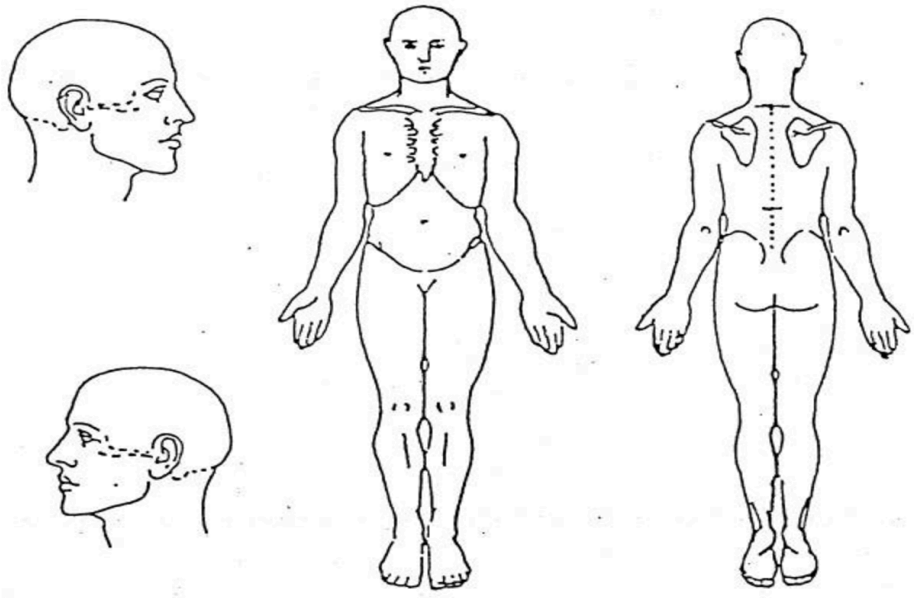
_____

Do you have any allergies (including but not limited to medications, supplements, food, stings/insect bites, etc.) □ Yes □ No
If YES, please explain:

_____

_____

Please fill in the diagram below for the condition(s) of which you are being treated in therapy:
xxx- stabbing ooo- numbness/tingling +++- pain sss - aching



Medications

Please list any medications (prescribed, over the counter, vitamins, etc) you are currently taking with dosage and frequency.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(Please use the space below if additional space is needed)

The statements above are true and complete to the best of my knowledge.

Name (print) _____

Signature _____ Date: _____