

EXOS PHYSICAL THERAPY AND SPORTS MEDICINE

MEDICAL HISTORY

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

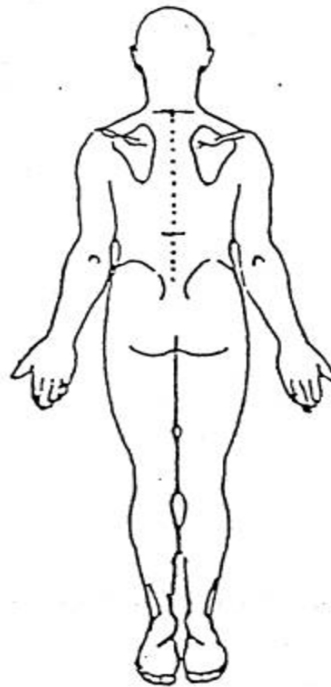
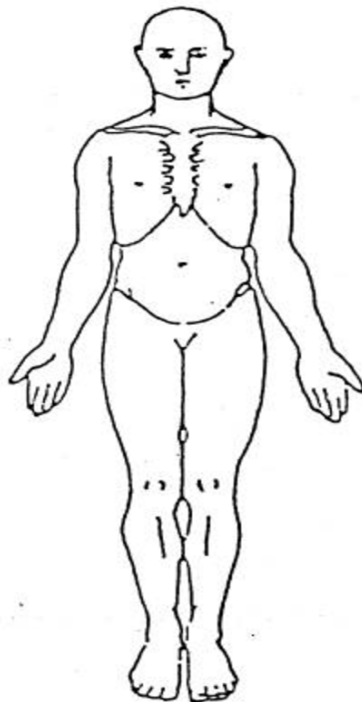
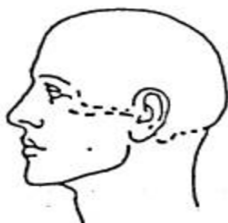
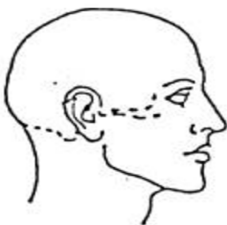
Please fill in the diagram below for the condition(s) of which you are being treated in therapy:

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.

Patient Print Name _____ Signature _____ Date _____

Guardian Print Name _____ Signature _____ Date _____