Health History Intake Form

NAME: ____ **DATE:**_________ **DOB:**____________

ADDRESS: ____ **TOWN:** _______________ **ZIP:** _______

PHONE #: _________________ **Cell:**_________________ **Email:** __________________

PHYSICIAN NAME: _________________________ **PHONE #:** ____________________

IN CASE OF EMERGENCY (NAME): ___________________________ **PHONE #:** _____________________

HEIGHT: ________ **WEIGHT:** _________

MEDICAL HEALTH HISTORY

When was your last physical examination performed by a physician? ____________________

Have you ever had a stress test or EKG?

Stress test: ☐ Yes ☐ No **EKG:** ☐ Yes ☐ No Physicians Name: __________________

Are you currently under a physician's care for an acute or chronic illness If Yes, please explain

Physician's Name: ____________________________ Phone:____

List current medications, how often you take them (include prescriptions and over-the-counter medications).

Please list any recent or prior surgeries or injuries :

Is there any medical concern that you may have that would prevent you from beginning an exercise program?

If yes, explain

Have you ever had your cholesterol checked? ☐ Yes ☐ No Date of test: ________________ **If known:**

Total cholesterol: _________ High-density lipoprotein (HDL): _________ Low-density lipoprotein (LDL): __________

Triglycerides: __________

Have you ever had your blood sugar checked? ☐ Yes ☐ No If known

Blood Glucose__________ HbA1c_____________

Please mark an (X) by all current conditions and (P) for all past conditions

_____ Allergies
_____ Anemia
_____ Angina (chest pain)
_____ Anxiety
_____ Arthritis
_____ Arrhythmia
_____ Asthma or lung condition
_____ Back/Neck Pain
_____ Bone/Joint Problems
_____ Blood clots
_____ Chronic pain
_____ Claudication (burning or cramping in legs)
_____ Depression
_____ Diabetes
_____ Difficulty breathing
_____ Edema (swelling)
_____ Emphysema
_____ Epilepsy
_____ Fainting
_____ Heart disease
_____ Heart Murmur
_____ Headaches, migraine

_____ Hearing problems
_____ Hernia
_____ High blood pressure
_____ Irregular heart rate
    _____ Rapid
    _____ Slow
_____ Kidney Disease
_____ Ligament injury
_____ Low blood pressure
_____ Muscle/Tendon injury
_____ Numbness/tingling
_____ Orthopedic injury
_____ Pregnancy
_____ Palpitations
_____ Sleep difficulties
_____ Spinal disorders
_____ Stress
_____ Stroke
_____ Unusual fatigue
_____ Vascular Disease
_____ Vision problems
_____Varicose veins
_____ Other

Medical Conditions

_____ Heart attack
_____ Heart surgery, cardiac catheterization, or coronary angioplasty
_____ Pacemaker/implantable cardiac defibrillator/rhythm disturbance
_____ Heart valve disease
_____ Heart failure
_____ Heart transplant
_____ congenital heart disease
_____ Diabetes
_____ Renal disease

Elaborate on noted areas above:

When you perform daily activity (climb stairs, walking) do you experience any of the following?
Shortness of breath_____ Dizziness_____ Headaches_____ Muscle cramps_____ Coughing____
Discomfort in joints_____

How many hours of sleep do you get per night? ___________

Check the category that best describes the type of work you perform(ed)?
________ Sedentary (sitting or driving)
________ Standing (such as a sales clerk)
________ Very Active (such as a physician, nurse, etc.)
________ Physically Active (laborer)

Physical Activity

Do you currently participate in any structured physical activity? ☐ Yes ☐ No If so, please describe:

__________ minutes of cardiorespiratory activity, __________ times per week

__________ muscular-training sessions per week

__________ flexibility-training sessions per week

__________ minutes of sports or recreational activities per week

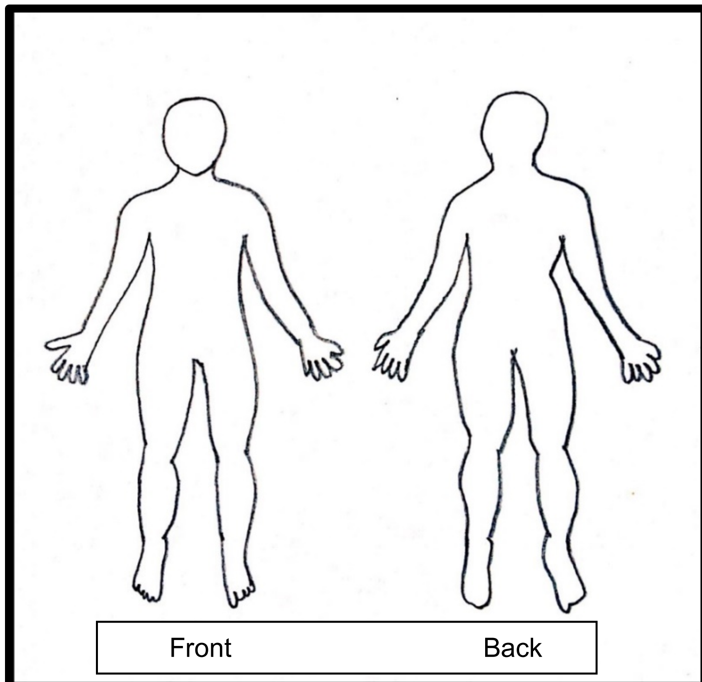
List sports or activities you participate in:
____

Do you engage in any other forms of regular physical activity? ☐ Yes ☐ No If yes, describe:
____

Have you ever experienced any injuries that may limit your physical activity? ☐ Yes ☐ No If yes, describe:
____

Do you have any physical-activity restrictions? If so, please list:____

Please use the letters in the key below to identify any symptoms that you may be currently or have previously experienced. Circle the area around each letter, representing the size and shape of each symptom location.



P= pain or tenderness
S= joint or muscle stiffness
N= numbness or tingling