**MEDICAL HISTORY REVIEW FORM**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In Case of Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_

Doctors Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under a doctor’s care: Yes ⬜️ No ⬜️

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the last time you had a physical examination?

Have you ever had an exercise stress test: Yes ⬜️ No ⬜️

Do you take any medications on a regular basis? Yes ⬜️ No ⬜️

If yes, please list medications and reasons for taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been recently hospitalized? Yes ⬜️ No ⬜️

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? Yes ⬜️ No ⬜️

Are you pregnant? Yes ⬜️ No ⬜️

Do you drink alcohol more than three times/week? Yes ⬜️ No ⬜️

Is your stress level high? Yes ⬜️ No ⬜️

Are you moderately active on most days of the week? Yes ⬜️ No ⬜️

Do you have:

High blood pressure? Yes ⬜️ No ⬜️

High cholesterol? Yes ⬜️ No ⬜️

Diabetes? Yes ⬜️ No ⬜️

Have parents or siblings who, prior to age 55 had:

A heart attack? Yes ⬜️ No ⬜️

A stroke? Yes ⬜️ No ⬜️

High blood pressure? Yes ⬜️ No ⬜️

High cholesterol? Yes ⬜️ No ⬜️

Known heart disease? Yes ⬜️ No ⬜️

Rheumatic heart disease? Yes ⬜️ No ⬜️

A heart murmur? Yes ⬜️ No ⬜️

Chest pain with exertion? Yes ⬜️ No ⬜️

Irregular heart beat or palpitations? Yes ⬜️ No ⬜️

Lightheadedness or do you faint? Yes ⬜️ No ⬜️

Unusual shortness of breath? Yes ⬜️ No ⬜️

Cramping pains in legs or feet? Yes ⬜️ No ⬜️

Emphysema? Yes ⬜️ No ⬜️

Epilepsy? Yes ⬜️ No ⬜️

Asthma? Yes ⬜️ No ⬜️

Other metabolic disorders (thyroid, kidney, etc.)? Yes ⬜️ No ⬜️

Back pain: upper, middle, lower? Yes ⬜️ No ⬜️

Other joint pain (explain on back of form)? Yes ⬜️ No ⬜️

Muscle pain or an injury (explain on back of Form)? Yes ⬜️ No ⬜️

To the best of my knowledge, the above information is true.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_