



EXTENDED EXERCISE PROGRAM (EEP) MEDICAL HISTORY

Personal Information

Name: Age: Birthdate: Sex:

Home Address: Phone:

Alt. Phone:

Last day of physical therapy: Diagnosis:

Primary Therapist:

Emergency Information

Personal Physician: Phone:

Referring Physician: Phone:

Do you have medical alert identification? If yes, where is it located?

List any allergies:

Person to be notified in case of emergency:

Relationship to you: Phone:

Work Phone: Pager/Cell:

Current Medications:

Have you been hospitalized in the past 6 months? Yes No If yes, why?

Please check the following diseases or conditions that you currently have:

High Pressure	Blood	High Cholesterol	Angina Pain	Heart Attack
Heart Surgery		Heart Murmur	Arteriosclerosis	Aneurysm
Anemia		Infectious Mononucleosis	Hepatitis	Diabetes
Gout		Asthma	Pneumonia	Bronchitis
Emphysema		Thyroid Problems	Hernia	Cancer
Epilepsy or Seizures		Other:		

Have you experienced any of the following on a recurring basis?

	At rest: YES	During exertion: YES
Shortness of breath		
Dizziness or fainting		
Daily coughing		
Chest pressure		
Chest pain		
Joint soreness		
Joint swelling		
Skipped heart beats		
Fast heart rate		
Sudden numbness or tingling		
Blurring vision		
Please explain any checked categories above:		

Do you smoke: Yes No

Exercise/Recreational History

Please list any physical and recreational activities in which you participate that entail sustained physical exertion (walking, running, lifting, carrying, etc) _____

Do you have any physician ordered restrictions on your activity level?: _____

Goals for exercise (weight management, stress management, general fitness, etc): _____
