



### F.I.T. 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? \_\_\_\_\_

\_\_\_\_\_

## Personal Medical History

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

<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Angina Pain	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Arteriosclerosis	<input type="checkbox"/>	Aneurysm
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Infectious Mononucleosis	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/> Other:					

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

	At rest: YES	During exertion: YES
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or fainting	<input type="checkbox"/>	<input type="checkbox"/>
Daily coughing	<input type="checkbox"/>	<input type="checkbox"/>
Chest pressure	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Joint soreness	<input type="checkbox"/>	<input type="checkbox"/>
Joint swelling	<input type="checkbox"/>	<input type="checkbox"/>
Skipped heart beats	<input type="checkbox"/>	<input type="checkbox"/>
Fast heart rate	<input type="checkbox"/>	<input type="checkbox"/>
Sudden numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>
Blurring vision	<input type="checkbox"/>	<input type="checkbox"/>
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):\_\_\_\_\_

\_\_\_\_\_