MEDICAL HISTORY QUESTIONNAIRE

KIMBIA PHYSIO
DYNAMIC & PERFORMANCE PT

This is your medical history form, to be completed prior to your first visit. All information will be kept confidential. This information will be used for the evaluation of your health and readiness to begin our exercise program. The form is extensive, but please try to make it as accurate and complete as possible. Please take your time and complete it carefully and thoroughly, and then review it to be certain you have not left anything out. Your answers will help us design a comprehensive program that meets your individual needs.

If you have questions or concerns, we will help you with those after this form is completed. We realize that some parts of the form will be unclear to you. Do your best to complete the form. Your questions will be thoroughly addressed afterwards. It might be helpful for you to keep a written list of questions or concerns as you complete the medical history form.

Name: _____

Signature: _____

Date: _____

MEDICAL HISTORY AND SCREENING FORM

General Information

Participant:

Name _____

Address _____

Contact phone numbers _____

Birth date _____

Family Physician and/or Primary Health Care Provider:

Doctor/Other _____ Phone _____

Address _____ City _____

May I send a copy of your consultation to your physician or primary health care provider and consult with them as necessary?

☐ Yes ☐ No

Signature:

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Sex:

☐ Male ☐ Female

Education:

☐ Grade School ☐ Jr. High School ☐ High School

☐ College (2-4 years) ☐ Graduate School ☐ Degree _____

Occupation:

Position _____ Employer _____

Address _____

Phone _____

Present Medical History

Check those questions to which you answer yes (leave the others blank).

- ☐ Has a doctor ever said your blood pressure was too high?
- ☐ Do you ever have pain in your chest or heart?

- ☐ Are you often bothered by a thumping of the heart?
- ☐ Does your heart often race?
- ☐ Do you ever notice extra heartbeats or skipped beats?
- ☐ Are your ankles often badly swollen?
- ☐ Do cold hands or feet trouble you even in hot weather?
- ☐ Has a doctor ever said that you have or have had heart trouble, an abnormal electrocardiogram (ECG or EKG), heart attack or coronary?
- ☐ Do you suffer from frequent cramps in your legs?
- ☐ Do you often have difficulty breathing?
- ☐ Do you get out of breath long before anyone else?
- ☐ Do you sometimes get out of breath when sitting still or sleeping?
- ☐ Has a doctor ever told you your cholesterol level was high?
- ☐ **Has a doctor ever told you that you have an abdominal aortic aneurysm?**
- ☐ **Has a doctor ever told you that you have critical aortic stenosis?**

Comments: _____
_____
_____
_____

Past Medical History

Check those questions to which your answer is yes (leave others blank).

- ☐ Heart attack if so, how many years ago? _____
- ☐ Rheumatic Fever
- ☐ Heart murmur
- ☐ Diseases of the arteries
- ☐ Varicose veins
- ☐ Arthritis of legs or arms
- ☐ Diabetes or abnormal blood-sugar tests
- ☐ Dizziness or fainting spells
- ☐ Stroke
- ☐ Nervous or emotional problems
- ☐ Anemia
- ☐ Thyroid problems
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Asthma
- ☐ Abnormal chest X-ray
- ☐ Other lung disease
- ☐ Injuries to back, arms, legs or joint
- ☐ Broken bones
- ☐ Jaundice or gall bladder problems

Comments: _____
_____
_____
_____

Other Heart Disease Risk Factors

Smoking

Have you ever smoked cigarettes, cigars or a pipe?

☐ Yes ☐ No

If you did or now smoke cigarettes, how many per day? _____ Age started _____

Do you ever drink alcoholic beverages?

☐ Yes ☐ No

If yes, what is your approximate intake of these beverages?

Beer:

☐ None ☐ Occasional ☐ Often If often, _____ per week

Wine:

☐ None ☐ Occasional ☐ Often If often, _____ per week

Hard Liquor:

☐ None ☐ Occasional ☐ Often If often, _____ per week

At any time in the past, were you a heavy drinker (consumption of six ounces of hard liquor per day or more)?

☐ Yes ☐ No

Comments: _____
_____
_____
_____