Medical Exercise Solutions, LLC
4305 Serene Circle, Ste 101
Fruitland Park, FL 34731
352.636.5361 |
medicalexercisesolutions@gmail.com

Medical History Form

General Information:

Name: Client # Date:
Address:
City: State: Zip:
Telephone: [home]: ( ) [work]: ( )
Age: Sex: Height: Weight:
Physician: Diagnosis:
Date of Injury or Condition Onset:
Insurance Carrier: Claim No:
Claims Adjuster: Phone No: ( )

1.	Has your doctor ever said you have any cardiovascular problems?	☐ Yes	☐ No
2.	Do you frequently suffer from chest pains?	☐ Yes	☐ No
3.	Have you ever had a heart attack?	☐ Yes	☐ No
4.	Do you ever experience an irregular or racing heart rate during exercise or at rest?	☐ Yes	☐ No
5.	Do you often feel faint or have spells of severe dizziness?	☐ Yes	☐ No
6.	Has a doctor ever said that your blood pressure is too high?	☐ Yes	☐ No
7.	Do you often have difficulty breathing?	☐ Yes	☐ No
8.	Has a doctor ever told you that you have a bone or joint problem such as arthritis that has been aggravated by exercise, or might be aggravated with exercise?	☐ Yes	☐ No
9.	Is there a good physical reason not mentioned here why you should not follow an activity program even if you wanted to?	☐ Yes	☐ No
10.	Are you over age 65 and not accustomed to vigorous exercise?	☐ Yes	☐ No
11.	Are you a diabetic?	☐ Yes	☐ No
12.	Are you pregnant?	☐ Yes	☐ No

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MEDICAL INFORMATION					
1.	Date of last physician visit:				
2.	List any medications you are now taking and the reason for which they were prescribed:				
3.	Describe your condition:				
4.	List any surgical procedures you have undergone:				
5.	Have you received physical therapy or chiropractic care?				
6.	Have you or any member of your immediate family (mother, father, sister or				
	brother) been diagnosed with:	Heart Disease:			
	Diabetes:	Hypertension:			
	Stroke:	High Cholesterol:			
	Obesity:	Hyperthyroidism:			
7.	How many hours a week do you work? ☐ 20 ☐ 30 ☐ 40 ☐ 50				
8.	How do you spend most of your time at work?				
	☐ Sitting ☐ Standing ☐ Carrying Loads ☐ Driving ☐ Walking				
9.	Do you smoke? ☐ Yes ☐ No				
10.	How many times per week do you engage in moderate or strenuous exercise for at least 30 minutes? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ >5				
11.	Do you have any pain when exercising? If yes, rate on a scale of 1–10.				
Signature:_____ Date:					

In case of emergency, notify the following person:				
Name:		Phone:	[home]	
Address:			[work]	
City:	State:		Zip:	

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