



Medical Exercise
Solutions, LLC

Medical Exercise Solutions, LLC
4305 Serene Circle, Ste 101
Fruitland Park, FL 34731
[352.636.5361](tel:352.636.5361) |
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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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Do you frequently suffer from chest pains?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Have you ever had a heart attack?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Do you ever experience an irregular or racing heart rate during exercise or at rest?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Do you often feel faint or have spells of severe dizziness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	Has a doctor ever said that your blood pressure is too high?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Do you often have difficulty breathing?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Is there a good physical reason not mentioned here why you should not follow an activity program even if you wanted to?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10.	Are you over age 65 and not accustomed to vigorous exercise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11.	Are you a diabetic?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12.	Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No



Medical History Form

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:		
	Diabetes:	Heart Disease:	
	Stroke:	Hypertension:	
	Obesity:	High Cholesterol:	
		Hyperthyroidism:	
7.	How many hours a week do you work? <input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 40 <input type="checkbox"/> 50		
8.	How do you spend most of your time at work?		
	<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Carrying Loads <input type="checkbox"/> Driving <input type="checkbox"/> Walking		
9.	Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No		
10.	How many times per week do you engage in moderate or strenuous exercise for at least 30 minutes? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> >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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