Name: _____ Birthdate: _____

Home Address: _____ Phone Number: _____

Gender: ____ Male ____ Female T#: _____ Marital Status: ____ S ____ M ___ D ___ W

Emergency Contact Information: Name _____ Phone Number _____

Family Physician: Name _____ Phone Number _____

PAST MEDICAL HISTORY

Have you had any of the following conditions or related conditions? If "yes," please describe. List frequency and severity, medications or surgery.

____Yes ___ No Respiratory System: hay fever, asthma, tuberculosis, sinus problems? _____

____Yes ___ No Cardiovascular: palpitations, high/low blood pressure, chest pain, heart murmur, heart disease? _____

____Yes ___ No Blood Disease Disorders: anemia, bleeding tendencies? _____

____Yes ___ No Muscle-Skeletal: "trick" knee, back problems, broken bones, recurrent sprains/tendonitis, deformities, arthritis? _____

____Yes ___ No Endocrine: thyroid, diabetes, adrenal? _____

____Yes ___ No Gastrointestinal: ulcer, gallbladder, diarrhea, constipation? _____

____Yes ___ No Genitourinary: menstrual problem, kidney/bladder problems, prostatitis, vaginal infections? _____

____Yes ___ No Neurological: seizures, hearing problems, head injury with unconsciousness? _____

____Yes ___ No Psychological: anxiety, depression, other emotional disorders? _____

____Yes ___ No Infections: rheumatic fever, malaria, hepatitis? _____

____Yes ___ No Surgeries: tonsillectomy, appendectomy, hernia repair, other? _____

____Yes ___ No Tumor/cyst/cancer? _____

CURRENT MEDICAL HISTORY

____Yes ___ No Allergies: medicines, bee stings, other? If "yes", please list: _____

____Yes ___ No Are you currently taking any prescribed drugs or medical treatment (including birth control pills)? _____

____Yes ___ No Do you know any reasons why you should not participate in normal physical exercise? _____

____Yes ___ No Do you have any questions regarding your health or other matters you'd like to discuss with the Health Services staff? ____ No ____ Yes