TOTAL BODY ENERGY
health • hydrate • happiness

MEDICAL HISTORY QUESTIONNAIRE

This is your medical history form, to be completed prior to your first session. All information will be kept confidential. This information will be used for the evaluation of your health and readiness to begin our 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: _____

Date: _____

Name: _____ DOB: _____ Sex: ☐ M ☐ F

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Email address: _____

Race: ☐ White ☐ Black or African American ☐ Asian
☐ Native American or Alaska Native ☐ Native Hawaiian or other Pacific Islander
☐ Decline to Provide ☐ Other: _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Decline to Provide

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Education: ☐ Grade School ☐ Jr. High School ☐ High School
☐ College (2-4 years) ☐ Graduate School ☐ Technical School

Occupation: _____

What is (are) your reasons (s) for participation in this Program?

☐ Rehydration to replace vital nutrients lost during exercise or illness.

☐ Other (please explain):

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?

Or

- ☐ None Apply

Do you now have or have you recently experienced:

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

- ☐ Chronic, recurrent or morning cough?
- ☐ Episode of coughing up blood?
- ☐ Increased anxiety or depression?
- ☐ Problems with recurrent fatigue, trouble sleeping or increased irritability?
- ☐ Migraine or recurrent headaches?
- ☐ Swollen, stiff or painful joints?
- ☐ Pain in your legs after walking short distances?
- ☐ Foot problems?
- ☐ Back problems?
- ☐ Stomach or intestinal problems, such as recurrent heartburn, ulcers, constipation or diarrhea?
- ☐ Significant vision or hearing problems?
- ☐ Recent change in a wart or a mole?
- ☐ Glaucoma or increased pressure in the eyes?
- ☐ Exposure to loud noises for long periods?
- ☐ An infection such as pneumonia accompanied by a fever?
- ☐ Significant unexplained weight loss?
- ☐ A fever, which can cause dehydration and rapid heart beat?
- ☐ A deep vein thrombosis (blood clot)?
- ☐ A hernia that is causing symptoms?
- ☐ Foot or ankle sores that won't heal?
- ☐ Persistent pain or problems walking after you have fallen?

☐ Eye conditions such as bleeding in the retina or detached retina?

☐ Cataract or lens transplant?

☐ Laser treatment or other eye surgery?

Or

☐ None Apply

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

☐ Menstrual period problems?

☐ Significant childbirth - related problems?

☐ Urine loss when you cough, sneeze or laugh?

☐ Currently receiving hormone replacement therapy?

☐ Date of the last pelvic exam and/or Pap smear: _____

Past Medical History

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

☐ Rheumatic Fever

☐ Heart murmur

☐ Diseases of the arteries

☐ Varicose veins

☐ Arthritis of legs or arms

☐ Diabetes or abnormal blood-sugar tests

☐ Phlebitis (inflammation of a vein)

☐ Dizziness or fainting spells

☐ Epilepsy or seizures

☐ Stroke

☐ Diphtheria

☐ Scarlet Fever

☐ Infectious mononucleosis

☐ 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

☐ Heart attack if so, how many years ago? _____

Or

☐ None Apply

List any prescription medications you are now taking:

List any self-prescribed medications, dietary supplements, or vitamins you are now taking:

Date of last complete physical examination: _____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

List any drug allergies:

Have you ever smoked? ☐ Yes ☐ No If yes,

Cigarettes: ☐ Past ☐ Currently

Cigars: ☐ Past ☐ Currently

Pipe: ☐ Past ☐ Currently

Do you ever drink alcoholic beverages? ☐ Yes ☐ No If yes,

Beer: ☐ Occasional (1 – 3 times per week) ☐ Often (3+ times per week)

Wine: ☐ Occasional (1 – 3 times per week) ☐ Often (3+ times per week)

Hard Liquor: ☐ Occasional (1 – 3 times per week) ☐ Often (3+ times per week)

My current height is: _____in. My current weight is: _____lbs.