

## Patient Medical History and Health Risk Profile

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: Male ( ) Female ( )

**Emergency contact:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

1) Problems to be treated today: \_\_\_\_\_

Have you had treatment for this problem before? ( ) Yes ( ) No When: \_\_\_\_\_

Please describe the type of treatment: \_\_\_\_\_

Have you had surgery associated with this problem? ( ) Yes ( ) No

If so, please list date and type: \_\_\_\_\_

2) Do you have any other condition that is aggravated by exercise? \_\_\_\_\_

3) Please list the names of any primary care physician / internist / cardiologist that you are seeing, or have seen in the past:

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

4) Are you currently pregnant? ( ) Yes ( ) No

5) Do you need assistance with any of the following?:

Transportation	Yes	No	Meals	Yes	No
Shopping/Errands	Yes	No	Personal Care	Yes	No
Domestic chores	Yes	No	Other _____	Yes	No

6) Has your illness / disability caused any of the following:

Financial Problems	Yes	No	Family Problems	Yes	No
Emotional Problems	Yes	No	Other _____	Yes	No

7) Do you have or have you had any of the following:

Feel faint or dizzy	Yes	No	Osteoporosis	Yes	No
Frequent pain in heart or chest	Yes	No	Known heart disease	Yes	No
Pacemaker	Yes	No	Diabetes	Yes	No
Headaches	Yes	No	Swollen ankles	Yes	No
Nervous disorders	Yes	No	Kidney problems	Yes	No
Allergies	Yes	No	Heat sensitivity	Yes	No
Seizures	Yes	No	Hernia	Yes	No
Balance problems	Yes	No	Metal implants	Yes	No
Hearing Problems	Yes	No	Vision problems	Yes	No
High cholesterol	Yes	No	High blood pressure	Yes	No
Cancer	Yes	No	Low blood pressure	Yes	No
			Tuberculosis	Yes	No
			Hepatitis	Yes	No

8) Please circle the closest answer or leave item blank if you do not know:

Cigarettes (per day)	Never	1-5	10-20	30-40	>50
Alcoholic drinks (per week)	Never	1-5	10-20	>20	
Cardiovascular Fitness (per week)	None	Occasional/Recreational		3+ days/week for at least 15 min.	

9) Respiratory Status:      Normal              Moderate              Severe (shortness of breath with mild exertion)

For office use only: I have reviewed the Health Risk Profile and the following is appropriate:

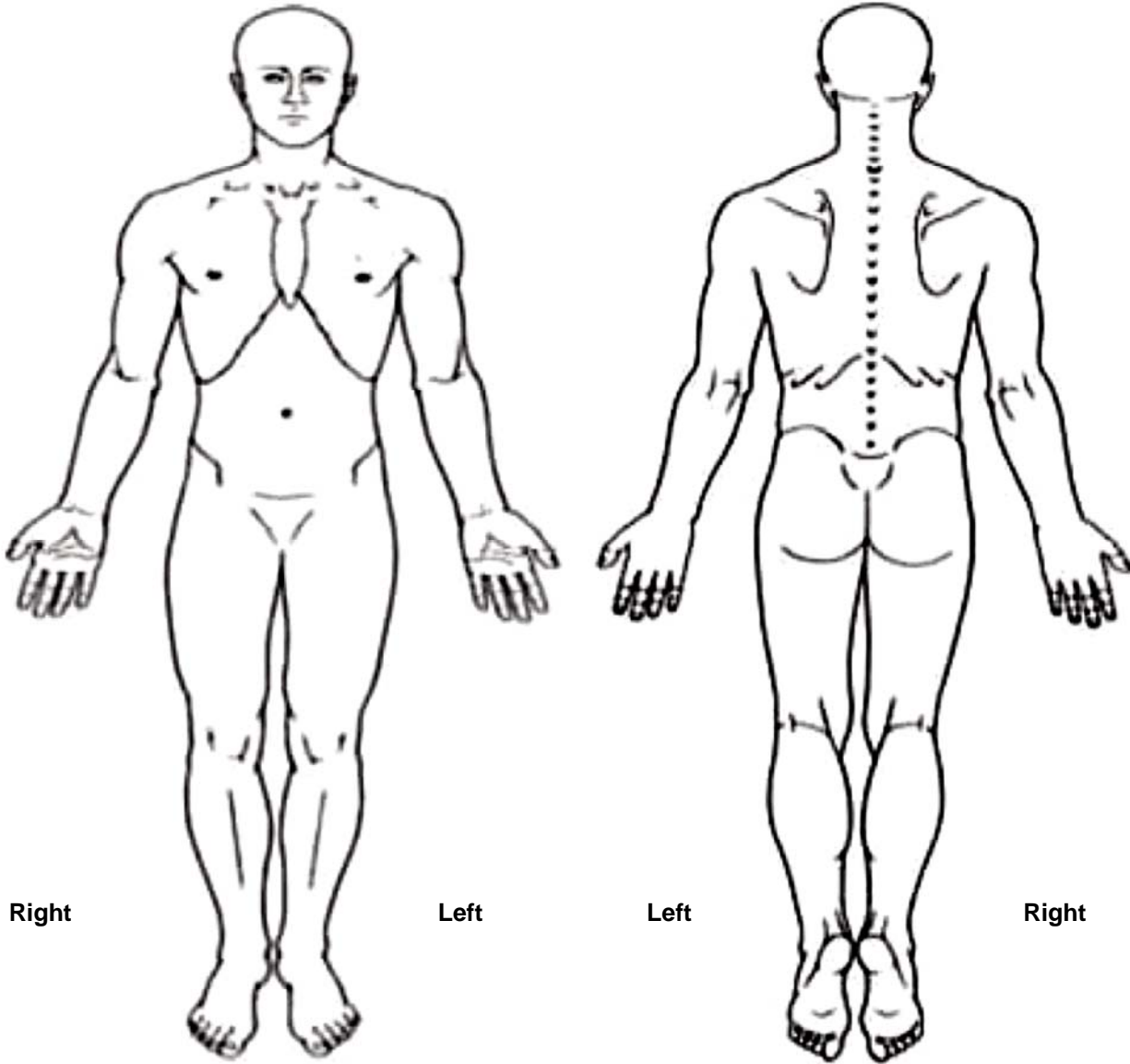
- Contact MD with CV Screening Request Form or request results of exercise test within last 2 years;
- Further cardiovascular screening is not necessary at this time.

Clinician Signature: \_\_\_\_\_

**WHERE IS YOUR PAIN NOW?**

Mark the areas on your body where you feel the described sensations.

ACHE	NUMBNESS	SPINS & NEEDLES	BURNING	STABBING
AAA	OOO	---	XXX	///
AAA	OOO	---	XXX	///
AAA	OOO	---	XXX	///



PLEASE MARK ON THE LINE WITH AN X THE DEGREE OF PAIN NOW

---

NO PAIN WORST PAIN

ARE YOU NOW:    BETTER\_\_\_\_\_    WORSE\_\_\_\_\_    SAME\_\_\_\_\_    SINCE THE PROCEDURE

Name: \_\_\_\_\_    Date: \_\_\_\_\_