PARKPOINTHEALTHCLUB.COM

health history

EXERCISE 2 WELLNESS CANCER RECOVERY PROGRAM

Name____ Today's date______________

Date of birth______________ Height__________ Weight__________ Sex__________

Phone______________ Cell______________ Email______________________

Address______________________ City______________ State_____ Zip________

Physician name________________________________ Phone______________

Emergency contact name ________________________ Phone______________

ONCOLOGY HISTORY

Type of cancer____________________________ Initial diagnosis (month/year)__________

Subsequent diagnosis/metastasis______________________ Month/year__________

Cancer treatment (check all that apply)

______ surgery ______________________________ date __________

______ radiation ______________________________ date __________

______ chemotherapy ______________________________ date __________

______ other therapy ______________________________ date __________

List of current medications____

____

ORTHOPEDIC

Do you have any of the following conditions that may limit your physical activity? (circle all that apply)

ankle/foot injury	bone fracture	shoulder/clavicle injury	arthritis
low back pain	nerve damage	arm/elbow injury	knee/thigh injury
hip/pelvic injury	upper back injury	wrist/hand injury	other

Please explain____

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MEDICAL HISTORY

Check if applicable	Yes	No	If yes, describe
diabetes			
high blood pressure			
high cholesterol			
angina/chest pain			
heart murmur			
irregular heart beats			
abnormal electrocardiogram			
rheumatic fever			
thrombophlebitis			
respiratory infections			
thyroid disease			
embolism			
aneurysm			
stroke			
valve disease			
heart attack			
asthma			
osteoporosis			
epilepsy			
headaches/migraines			

When exercising, including climbing stairs, do you ever experience any of the following? (circle all that apply)

chest pain
shortness of breath
pressure over the heart
a tired-out feeling
leg aches
dizziness

Additional information you would like us to know____________________

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