



HISTORY

Health and Medical History

NAME _____ SOCIAL SECURITY NUMBER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ WORK PHONE # _____ MOBILE# _____

EMAIL: _____

SEX: Male Female AGE _____ DATE OF BIRTH _____

MARITAL STATUS Single Married Legally Separated Divorced Widowed

OCCUPATION _____ EMPLOYER _____

EMPLOYER'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYER'S PHONE # _____

REFERRING PHYSICIAN _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

FAMILY PHYSICIAN _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SURGEON _____ RADIATION ONCOLOGIST _____

PLEASE LIST ANY ONE OF ABOVE MD'S YOU WOULD **NOT** LIKE COPY OF EVALUATION SENT TO _____

SPOUSE'S NAME _____ SPOUSE'S SOCIAL SECURITY # _____

SPOUSE'S DATE OF BIRTH _____

SPOUSE'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE'S HOME PHONE # _____ SPOUSE'S WORK PHONE # _____

IN CASE OF EMERGENCY, PLEASE CONTACT: _____

RELATIONSHIP _____ PHONE _____

ADDRESS _____

HOW DID YOU HEAR ABOUT WELLNESS ONE? _____

SYMPTOMS/ACTIVITY LEVEL

DATE OF INJURY/SURGERY/ONSET OF SYMPTOMS _____

DESCRIBE THE PROBLEMS YOU ARE HAVING (Relevant signs and symptoms) _____

LEVEL OF ACTIVITY: sedentary mildly active active very active

TYPE OF CURRENT ACTIVITY _____

RISK FACTOR QUESTIONNAIRE

YES NO

 1. Have you ever had, or has your doctor ever diagnosed you as having heart trouble or coronary disease?

 2. Do you have a family history of heart problems or coronary disease in your parents or siblings before age 55?

 3. Any cardiac surgeries? If yes please list _____

 4. Do you ever feel faint or have dizzy spells?

 5. Has your doctor ever said that your cholesterol was high?

 6. Do you experience shortness of breath during daily activities?

 7. Do you smoke cigarettes/cigars/a pipe? _____ per day

 8. Have you had a recent weight gain or loss? If yes, how much? _____

 9. Do you have a history of lymphedema (arm or leg swelling) in your family?

If yes, Who? _____

 10. Do you have any neurotoxicities (numbness and tingling) in your hands and feet?

 11. Any nausea or vomiting?

 12. Bone Mets? If yes where? _____

MEDICAL HISTORY

PLEASE CHECK ANY CONDITIONS OR DISEASES YOU NOW HAVE OR HAVE HAD IN THE PAST.

Stroke

Peripheral Vascular Disease

Phlebitis or blood clots

Lung disease

Low blood pressure

Heart murmur

Osteoporosis

Family history of arthritis or osteoporosis

Thyroid disease

Emphysema

Hernia

Arthritis

Bursitis

Back pain/or neck pain

MEDICAL HISTORY (continued)

- | | |
|-----------------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Heart edema / Congestive heart failure | <input type="checkbox"/> Recent falls |
| <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Unusual shortness of breath | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Light-headed, fainting | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Post-Polio |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Toxoplasmosis | <input type="checkbox"/> Chronic Fatigue Syndrome |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Sickle Cell anemia | <input type="checkbox"/> Elbow pain |
| <input type="checkbox"/> Immune suppressed illness | <input type="checkbox"/> Wrist/Hand pain |
| <input type="checkbox"/> Thyroid problems (hyper/hypo) | <input type="checkbox"/> Other (please explain) |

- Allergies (please list)

IF YOU CHECKED ANY ITEM LISTED ABOVE, PLEASE EXPLAIN.

1. List all the medications you are presently taking, including over-the-counter. **Please include the purpose of the medication.** _____

MEDICAL HISTORY (continued)

2. List any surgical procedures or hospitalizations within the past five years.

3. Have you had chemotherapy? Please list dates.

Date started: _____ Date completed: _____ Cycles complete: _____

| <u>Complications/Symptoms</u> | <u>Treatment Given</u> | <u>Chemo Drugs</u> | <u>Frequency</u> |
|-------------------------------|------------------------|--------------------|------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

4. Have you had radiation therapy? Please list dates and body area(s).

| <u>Location</u> | <u>Date Started</u> | <u>Date Completed</u> | <u>Complications/Problems</u> |
|-----------------|---------------------|-----------------------|-------------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

5. How often do you see a doctor, or need medical attention?

6. Have you ever had any physical or occupational therapy? yes no

If yes, where and when do you have the therapy?
