University of Illinois at Chicago
Human Performance Lab
Self-Administered Medical History Form

UIC HUMAN PERFORMANCE LABORATORY

Name: ______________________________________
Address: ________________________________
City/State/Zip: _______________________________
Birth Date: _____/_____/_____ Age: _____

Date: _______/ ________/ _______
Home Phone: ________________________
Work Phone: ________________________
Email: ________________________

Primary Physician: _______________________________
Address: ______________________________________
City/State/Zip Code______________________________

Referring Physician: ______________________
Address: ______________________________
City/State/Zip code:______________________

EMERGENCY CONTACT

Name/Relationship: ______________________________ Phone: _____________________

GENERAL MEDICAL HISTORY

*Check if **YOU** have had any of the following?* *Have any of your **FAMILY** members been diagnosed with the following?*

	Yes	No	Yes	Specify Relationship and Age
Diabetes				
Heart Disease				
High Blood Pressure				
Heart Murmur				
Artery Disease				
High Cholesterol				
Rheum/Scarlet Fever				
Tuberculosis				
Asthma				
Chronic Bronchitis				
Emphysema				
Hepatitis				
HIV				
Seizures				
Blood Disorders				
Kidney Disease				
Cancer				
Other				
Surgical Procedures				

Allergies: Yes ☐ No ☐ Specify: ____

Medication (including over the counter): ____

Supplements: ____

OTHER SIGNS AND SYMPTOMS

Have you experienced any of the following?

	Yes	No		Yes	No
Heart palpitations	☐	☐	Shortness of breath, upright	☐	☐
Chest pains at rest	☐	☐	Shortness of breath, supine	☐	☐
Chest pains on exertion	☐	☐	Shortness of breath, after walking 2 flights of stairs	☐	☐

Explain: ____

MUSCULAR BONE & JOINT INJURY

	Yes	No		Yes	No
Muscular injuries/illnesses	☐	☐	Swollen Joints	☐	☐
Muscular weakness	☐	☐	Painful joints	☐	☐
Muscular pain at rest	☐	☐	Flat feet	☐	☐
Any bone, joint, or spine injury or illness	☐	☐			

Explain: ____

SMOKING

Do you smoke now? Yes ☐ No ☐

How much per day? _______________________ How many years? _________________

Did you smoke in the past? Yes ☐ No ☐

How much per day? _______________________ How many years? _________________

In case you have stopped, when did you? ________ Why? ___________________________

HEIGHT AND WEIGHT

What is your current weight? __________________ What is your current height? _________

Weight loss or gain in the past 10 years? _________

Are you dieting? Yes ☐ No ☐ Why? ____

EXERCISE

Do you exercise regularly? Yes ☐ No ☐ Type of exercise(s): ________________________

Frequency/ week: __________________ Duration of each session: ____________________

Have you ever experienced an exercise-related injury? Yes ☐ No ☐

If yes, describe: ____

This form was filled out honestly and each answer is true to my best knowledge. I take responsibility for alerting my practitioner to any physical or emotional conditions that would affect my appointment.

Signature: _________________________________ Date: _____/_____/_____