University of Illinois at Chicago
UIC FitWell Center
Self-Administered Medical History Form

Name: ___________________________________ Date: ______/ ______/ ______
Address: _______________________________ Home Phone: ______________________
City/State/Zip: _____________________________ Work Phone: ______________________
Birth Date: _____/_____/_____ Age: _____ Email: ______________________

Primary Physician: _____________________________ Referring Physician: ____________________
Address: _____________________________________ Address: _____________________________
City/State/Zip Code___________________________ 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: _____/_____/_____