UIC FitWell Center

UIC Campus Recreation

Client Information

Name		Street Address Including City, State, and ZIP Code	
Date of Birth			
Preferred Pronouns		Age	
Preferred Email		Preferred Phone Number	
Primary Care Physician (PCP)		PCP Address including City, State, and ZIP codes	
Emergency Contact		Relation to Emergency Contact	
Emergency Contact Phone Number			

General Medical History.

Check if YOU have had any of the below	YES	NO	Have any of your family members been diagnosed with the following: 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	☐	☐	☐	

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Other Signs and Symptoms

	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 two flights of stairs	☐	☐

Muscular Bone and Joint Injury

Muscular injuries/illnesses	☐	☐	Swollen joints	☐	☐
Muscular weakness	☐	☐	Painful joints	☐	☐
Muscular pain at rest	☐	☐	Flat feet	☐	☐
Any bone, joint, or spine injury/illness	☐	☐			

Medications:_____

Supplements:_____

Smoking

	Yes	No		
Do you smoke now?	☐	☐	If yes, for how long?	
Have you smoked in the past?	☐	☐	When did you stop?	

Exercise

Do you exercise regularly?	☐	☐	If yes, what type?	
Have you experienced an exercise related injury?	☐	☐	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: _____