

Please complete all pages, write clearly, and fax to:

Ethan Carter, CPT

Tel: 760.722.2063

Fax: 760.722.2064

fit@ethancarter.com

MEDICAL HEALTH HISTORY & EMERGENCY INFORMATION

GENERAL INFORMATION

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Tel: _____ Work Tel: _____

E-Mail: _____

Birth Date: _____ Age: _____ Gender: _____

EMERGENCY INFORMATION

Contact Name: _____ Relationship: _____

Contact's Tel: _____

Physician's Name: _____ Physician's City: _____

Physician's Tel: _____

PERSONAL MEDICAL HISTORY

Please indicate if you **now have** or **have had** any of these conditions?

General:

- | | |
|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Murmurs |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Chest Pain/Discomfort | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irregular Heart Rhythm |
| <input type="checkbox"/> Emotional Disorders | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Respiratory Disorders |
| <input type="checkbox"/> Excessive Fatigue | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other: _____ |

Please further explain any answers given above: _____

Musculoskeletal Problems:

- | | |
|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Knee/Hip Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Muscular Weakness |
| <input type="checkbox"/> Former Injuries | <input type="checkbox"/> Painful Joints |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Joint Replacements | <input type="checkbox"/> Other: _____ |

Please further explain any answers given above: _____

Have you had any surgeries? If yes, please describe: _____

Have you had any other health problems? If yes, please describe: _____

Do you currently have any other condition that would affect your ability to do any type of strenuous exercise? If yes, please describe: _____

Please list any medications that you are **currently** taking (including hormones): _____

Do you currently smoke? Yes No

If yes, how much? _____

For how long? _____

FAMILY MEDICAL HISTORY

Have any of the following conditions been present in a blood relative? Please indicate if any of your parents, grandparents, aunts, uncles, or siblings **now have** or **have had** any of these conditions?

- | | |
|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Surgeries | <input type="checkbox"/> Other: _____ |

Please further explain any answers given above:

PHYSICAL ACTIVITY HISTORY

Please indicate the type and amount of exercise or activity that you do regularly:

- | | |
|---|---|
| <input type="checkbox"/> Aerobics | <input type="checkbox"/> Running |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Skiing |
| <input type="checkbox"/> Bicycling | <input type="checkbox"/> Snow Boarding |
| <input type="checkbox"/> Dancing | <input type="checkbox"/> Stretching |
| <input type="checkbox"/> Golf | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Hiking | <input type="checkbox"/> Tennis |
| <input type="checkbox"/> House and/or Yard Work | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Martial Arts | <input type="checkbox"/> Weight Lifting |
| <input type="checkbox"/> Pilates | <input type="checkbox"/> Yoga |
| <input type="checkbox"/> Racquetball | <input type="checkbox"/> Other: _____ |

GOALS

Please list your health and fitness goals. List short, medium, and long term goals:
