Omaha Sports Physical Therapy, PC
Medical and Exercise History

Name:____ Age:___________

Please check below if you currently or have ever had any of the following:

- ☐ Elevated blood pressure
- ☐ Coronary artery disease
- ☐ Heart attack
- ☐ Blood clot
- ☐ Thrombophlebitis
- ☐ Congestive heart failure
- ☐ Peripheral Vascular Disease (PVD)
- ☐ Diabetes
- ☐ Any other heart problem that would make exercise unsafe
- ☐ Respiratory dysfunction
- ☐ Asthma
- ☐ Bronchitis
- ☐ Unusual shortness of breath
- ☐ Epilepsy or seizures
- ☐ Cancer
- ☐ Rheumatism
- ☐ Current/recent pregnancy
- ☐ Osteoarthritis
- ☐ Low back/neck pain
- ☐ Joint dysfunction
- ☐ Bone dysfunction
- ☐ Muscle dysfunction
- ☐ Any physical disability that could interfere with safe exercise participation
- ☐ Latex Sensitivity
- ☐ Smoking
- ☐ Other________________________
____
____

Please explain any checked items____
____

List previous surgeries related to current condition_________________________
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____
____

List all medications are you currently taking

- ☐ Pain Medication
- ☐ Muscle Relaxants
- ☐ Anti-Inflammatory
- ☐ Hypertension/Cardiac

List any allergies:____
____

Are you currently participating in any competitive sports? ☐ Yes ☐ No
If yes, please list sport activities in which you currently participate:_____________
____

Do you currently exercise? ☐ Yes ☐ No
If yes, describe exercise type and frequency______________________________
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Patient's Signature_____________________________________Date___________

Parent's Signature (if minor)_____________________________Date___________