CLIENT PROFILE & HEALTH HISTORY

The health history form is a quick and effective way of screening patients about to participate in physical activity of anykind to ensure you are safely able to take part without risk to yourself. The questionnaire will identify health issues andrecent injuries, illness, ailments and cardiovascular conditions that require the attention of your Exercise Oncology Specialist prior to taking part in any type of physical training through any phase. The role of this form and screening process is not necessarily diagnostic but rather assessing risk.

Name _____ **Date** _____

Date of Birth (MM/DD/YR) _____ **Age** _____

Address _____

City _____ **State** _____ **Zip Code** _____

E-mail _____

Preferred Contact Number *(select and provide number)*

☐ Home _____ ☐ Cell _____ ☐ Work _____

Is it okay to leave a message? ☐ Yes ☐ No

Profession _____

Referred by

☐ Physician *(please provide name)* _____

☐ Family/Friend ☐ Website ☐ Social Media ☐ Other _____

Ethnicity

☐ American Indian/Alaska Native ☐ Asian ☐ American/Pacific Islander ☐ Black/Non-Hispanic

☐ White/Non-Hispanic ☐ Other _____ ☐ Prefer not to answer

Emergency Contact _____ **Phone** _____

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CLIENT PROFILE & HEALTH HISTORY

PRE-EXISTING CONDITIONS
(Check each condition that currently applies to you.)

Condition	Date	Additional Information
☐ High Blood Pressure	_____	_____
☐ Chest Discomfort	_____	_____
☐ Neuropathy	_____	_____
☐ Lung Disease	_____	_____
☐ Stomach or Intestinal Problems	_____	_____
☐ Anemia	_____	_____
☐ Stroke	_____	_____
☐ Migraine	_____	_____
☐ Dizziness or Fainting Spells	_____	_____
☐ Leg Pain	_____	_____
☐ Back/Neck Pain	_____	_____
☐ Lymphedema	_____	_____
☐ High Cholesterol	_____	_____
☐ Diabetes	_____	_____
☐ Thyroid Problems	_____	_____
☐ Respiratory Problems	_____	_____
☐ Fatigue	_____	_____
☐ Arthritis	_____	_____
☐ Epilepsy	_____	_____
☐ Anxiety/Depression	_____	_____

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CLIENT PROFILE & HEALTH HISTORY

PREVIOUS SURGERIES *(Non-cancer related)*

1. _____ **Date** _____

2. _____ **Date** _____

3. _____ **Date** _____

4. _____ **Date** _____

5. _____ **Date** _____

Are you a cigarette/cigar/pipe smoker? ☐ Yes ☐ No

If yes, how many or much do you smoke per day? _____

Were you previously a cigarette/cigar/pipe smoker? ☐ Yes ☐ No

If yes, when did you quit? _____

MEDICATION LIST *(Please include ALL medications.)*

Medication	Dose	Date Started
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

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CLIENT PROFILE & HEALTH HISTORY

MEDICAL HISTORY - CANCER

What was the date of your cancer diagnosis? (MM/YR) _____

What type of cancer were you diagnosed with? (e.g., breast, lung, prostate) _____

Please list specific location _____

What stage was your cancer? (Include stage with any parameter listed below.)

☐ 0 ☐ I ☐ II ☐ III ☐ IV ☐ Undetermined ☐ I don't know

☐ A ☐ B ☐ C ☐ D ☐ E ☐ S ☐ Other _____

What types of cancer treatments have you received, or will you receive in the future?

Surgeries ☐ No ☐ Current ☐ Complete Date (MM/YR) _____

Future Date (MM/YR) _____ Type(s) of Surgery (if applicable) _____

_____

Chemotherapy ☐ No ☐ Current ☐ Complete Date (MM/YR) _____

Future Date (MM/YR) _____ Type(s) of Chemotherapy (current or future) _____

_____

Radiation ☐ No ☐ Current ☐ Complete Date (MM/YR) _____

Future Date (MM/YR) _____

If radition was completed, how many total sessions did you have? _____

Lymph Nodes Removed ☐ No ☐ Current ☐ Complete Date (MM/YR) _____

Future Date (MM/YR) _____ If yes, how many were removed? _____

Drug Allergies _____

_____

_____

_____

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CLIENT PROFILE & HEALTH HISTORY

GENERAL INFORMATION

What is the main goal related to starting an exercise program?

☐ Physical Fitness ☐ Start a new activity or participate in an event _____

☐ Lose Weight ☐ Other _____

Do you anticipate any barriers to starting an exercise program?

☐ Lack of Time ☐ Lack of Enjoyment from Exercise ☐ Lack of Self-Discipline

☐ Lack of Equipment ☐ Fatigue or Feeling Unwell ☐ Weather ☐ Financial

☐ Other responsibilities (e.g., family, job, volunteer position) ☐ Other_____

Do you have any specific cancer-related concerns about exercise?

☐ Type of exercise that is safe during or following cancer treatment

☐ Risk of infection at the fitness center or public facilities ☐ Risk of developing lymphedema

☐ Knowledge of the Exercise Oncology Specialist related to working with cancer survivors

☐ Other _____

Are you currently active in an exercise program?

☐ No ☐ Yes (please specify) _____

How many days a week do you exercise?

☐ 0 ☐ 1 to 2 ☐ 3 to 4 ☐ 5+

Is your exercise light, moderate, or vigorous? _____

What types of physical activities do you currently do or have done in the past? _____

_____

_____

_____

_____