Institute for Exercise and Environmental Medicine

Texas Health Presbyterian Hospital DALLAS | UT Southwestern Medical Center

REGISTRATION INFORMATION			
Full Legal Name:		Preferred Name:	
Date of Birth:	SSN:	Sex:	Preferred Pronoun(s):
Marital Status: ☐Single ☐Married ☐Domestic Partner		Race: ☐Asian ☐Black ☐White ☐Native American ☐Native Hawaiian / Pacific Islander ☐Two or more races	
Ethnicity: ☐Hispanic ☐non-Hispanic			
Religious Preference:			
Mobile:		Address:	
Home:			
Work:		Mailing Address: (if different)	
Email:			

EMERGENCY CONTACT:	
Name:	Relationship:
Phone:	

EMPLOYMENT				
Occupation:				
Employer:				
Employment Status:				
☐ Full Time	☐ Part Time	☐ Retired	☐ Self-Employed	☐ Child/Minor
☐ Disabled	☐ Not Employed	☐ Homemaker	☐ Student – Full Time	☐ Student – Part Time
☐ Active Military Duty		☐ Retired Military		☐ Other:

HEALTH INSURANCE INFORMATION		
Guarantor (If other than self)	Name:	Address:
	Date of Birth:	
	Relationship:	
Primary Insurance	Name:	Plan:
	Member ID:	Group:
	Subscriber Name:	
	Subscriber DOB:	
	Relationship:	
Secondary Insurance	Name:	Plan:
	Member ID:	Group:
	Subscriber Name:	
	Subscriber DOB:	
	Relationship:	

MEDICATION AND PHARMACY INFORMATION				
Medications				
Medication	Dosage	How often?	Taken when?	Last Dose Taken?
Example: Lasix	40 mg	Twice a day	Morning, Night	This morning
Medications Discontinued within Last 6 Months				
Medication	Dosage	How often?	Taken when?	Last Dose Taken?

Pharmacy	
Pharmacy Name:	Address:
Phone:	

ALLERGIES Please list any medication, foods, or substance, such as contrast dye or iodine, that you are allergic to, had an adverse reaction to or do not tolerate and describe the reaction.	
Name of Medication, Food or Substance	**Type of Reaction**
Example: Lipitor	Hives, Muscle Aches

MEDICAL RECORDS			
Current Medical Providers (beginning with who referred you)			
Provider Name:	Location:	Last Seen?	Seen for?

Procedures / Diagnostic Testing			
If you have had any of the following, please write in the year it was completed.			
	Muscle Biopsy	Imaging:	
	EMG		MRI (brain, spine, muscle)
	Genetic Testing		Other:

CHIEF COMPLAINT

What problem(s) are you here for today?

Date of Onset:

Symptoms

Please check if you have been experiencing any of the following:

CONSTITUTION

- ☐ Chills
- ☐ Weight Loss
- ☐ Fatigue
- ☐ Sweating or Perspiration
- ☐ Weakness

SKIN

- ☐ Rash
- ☐ Itching

NEUROMUSCULAR

- ☐ Dizziness
- ☐ Tingling
- ☐ Tremor
- ☐ Sensory Change
- ☐ Speech Change
- ☐ Focal Weakness
- ☐ Seizures
- ☐ Loss of Consciousness
- ☐ Muscle Weakness

EYES

- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Sensitive to Light
- ☐ Tunnel Vision
- ☐ Blackouts
- ☐ Spots in Vision

HENT

- ☐ Headaches
- ☐ Hearing Loss
- ☐ Ringing in the Ears
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Congestion
- ☐ Sore Throat

RESPIRATORY

- ☐ Cough
- ☐ Coughing up Blood
- ☐ Sputum Production
- ☐ Short of Breath
- ☐ Wheezing

GASTROINTESTINAL

- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in Stool
- ☐ Black Stook

GENITOURINARY

- ☐ Painful Urination
- ☐ Urgency
- ☐ Urinary Frequency
- ☐ Blood in Urine
- ☐ Flank Pain

MUSCULOSKELETAL

- ☐ Muscle Pain
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Falls

ENDO/HEME/ALL

- ☐ Easy Bruising
- ☐ Allergies
- ☐ Excessive Thirst

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Palpitations or Flutters
- ☐ Leg Swelling
- ☐ Leg Pain while Walking
- ☐ Shortness of Breath When Laying Down
- ☐ Waking from Sleep Short of Breath

PSYCHIATRIC

- ☐ Depression
- ☐ Suicidal Ideas
- ☐ Substance Abuse
- ☐ Hallucinations
- ☐ Nervous/Anxious
- ☐ Insomnia
- ☐ Memory Loss

FAMILY HISTORY

Please indicate if any of your family members have or had any medical conditions.

Example: muscle weakness, metabolic myopathy, Rhabdomyolysis, high blood pressure, enlarged heart, lung, liver or thyroid problems, cancer, diabetes

Family Member:	Medical Condition(s):
Father	
Mother	
Sibling(s)	
Maternal Grandparent(s)	
Paternal Grandparent(s)	
Aunt	
Uncle	
Children	
Other: _____	

☐ Check here if adopted and do not know your family history

SOCIAL HISTORY				
Please answer the following questions about your home support systems.				
With whom do you live?				
Any difficulty affording housing, food, medications?				
Who is your primary support system?				
Who is your primary support system for health needs?				
Number of children:		Ages:		
Lifestyle				
Do you use tobacco?	☐ Yes ☐ Never ☐ Formerly, quit date: Type: ☐ Cigarettes ☐ Electronic Cigarettes ☐ Cigars ☐ Pipes ☐ Snuff ☐ Chewing Tobacco		Amount per day:	For how long?
Do you use recreational drugs?	☐ Yes ☐ Never ☐ Formerly, quit date: Type: ☐ Marijuana ☐ Methamphetamine ☐ Cocaine ☐ Heroin ☐ Other		Amount per day:	For how long?
Diet				
Do you drink alcohol?	☐ Yes ☐ Never ☐ Formerly, quit date: Type: ☐ Beer ☐ Wine ☐ Spirits		Amount per day:	For how long?
Do you drink caffeine?	☐ Yes ☐ Never ☐ Formerly, quit date: Type: ☐ Coffee ☐ Soda ☐ Tea		Amount per day:	For how long?
On a special diet?	☐ Yes ☐ No If yes, what type?			
Activity				
Do you exercise?	☐ No ☐Physically Unable ☐ Occasionally ☐ Regularly ☐ Competitively			
At what intensity?	☐ Light ☐ Moderate ☐ High ☐ Vigorous ☐ Extreme			
Please list …				

Type of Exercise	How many days per week?	How many minutes per day?