## Institute for Exercise and Environmental Medicine



## UTSouthwestern Medical Center

REGISTRATION INFORMATION								
Full Legal Name:		Preferred N	Preferred Name:					
Date of Birth:	SSN	l:	Sex:	Sex: Preferred Pronoun(s):				
Marital Status: □Single □Married □Domestic Partner			Race: □As	sian □Black	☐White ☐Native American			
Ethnicity: □Hispanic □non-Hispanic			□N	□Native Hawaiian / Pacific Islander				
Religious Preference:			□Τν	wo or more r	races			
Mobile:			Address:	Address:				
Home:								
Work:			Mailing Add	Mailing Address:				
Email:			(if different	t)				
		EMERGEN	ICY CONTACT					
Name:			Relationshi	p:				
Phone:								
	-							
EMPLOYMENT								
Occupation:								
Employer:								
Employment Status:								
☐ Full Time ☐ F	Part Time	☐ Retired	☐ Self-Emplo	☐ Self-Employed ☐ Child/Minor				
☐ Disabled ☐ N	☐ Not Employed ☐ Homemaker		$\square$ Student –	Full Time	☐ Student – Part Time			
☐ Active Military Duty ☐ Retired Military		У		☐ Other:				
		HEALTH INSURA	ANCE INFORM	TATION				
Guarantor	Name:			Addı	Address:			
(If other than self)	Date of Birth:							
	Relationship:							
Primary Insurance Name:				Plan:				
Member ID:				Group:				
Subscriber Name:								
Subscriber DOB:								
	Relationship:							
Secondary Insurance	Name:			Plan:				
	Member ID:			Grou	nb:			
	Subscriber Na							
	Subscriber DO	OB:						
	Relationship:							

Medications								
Medication	Dosage	How often?	Taken when?	Last Dose Taken?				
Example: Lasix	40 mg	Twice a day	Morning, Night	This morning				
			ued within Last 6 N					
Medication	Dosage	How often?	Taken when?	Last Dose Taken?				
		Dha						
Dhawa ay Maya ay		Pna	rmacy					
Pharmacy Name: Phone:		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, Foo	od or Substance	e		Type of Reaction				
Example: Lipitor			Hives, Muscl	e Aches				

**MEDICATION AND PHARMACY INFORMATION** 

	MEDICAL RE	CORDS						
Curre	ent Medical Providers (begin	ning with who refe	rred you)					
Provider Name:	Location:	Last Seen?	Seen for?					
Relevant Surgeries and Procedures								
Surgery / Procedure:	Location:	Date:	Name of Surgeon / Specialist:					
	Relevant Hospital and Em	ergency Room Visi	ts					
Date(s):	Location:	How long?	Seen for?					
		i .						

What problem(s) are you here for today?	CHIEF COMPLAINT							
Please check if you have been experiencing any of the following:  CONSTITUTION EYES GASTROINTESTINAL ENDO/HEME/ALL  Chills   Bilurred Vision   Heartburn   Easy Bruising    Weight Loss   Double Vision   Nausea   Allergies    Fatigue   Sensitive to Light   Vomiting   Excessive Thirst    Sweating or Perspiration   Tunnel Vision   Addominal Pain   NEUROLOGICAL    Weakness   Blackouts   Diarrhea   Dizziness    SKIN   Spots in Vision   Constipation   Tringling    Rash   HENT   Blood in Stool   Tremor    Itching   Headaches   Black Stook   Sensory Change    CARDIOVASCULAR   Hearing Loss   GENITOURINARY   Speech Change    CARDIOVASCULAR   Ringing in the Ears   Painful Urination   Focal Weakness    Deal patiations or Flutters   Loss of Smell   Urgency   Loss of Consciousness    Leg Swelling   Loss of Taste   Urinary Frequency   Loss of Consciousness    Leg Pain while Walking   Congestion   Blood in Urine    Short of Breath   Sover Throat   Flank Pain   Depression    Waking from Sleep   Cough   MusculoSKELETAL   Suicidal Ideas    Waking from Sleep   Cough   MusculoSKELETAL   Suicidal Ideas    Short of Breath   Short of Breath   Short of Breath   Short of Breath   Hallucinations    Short of Breath   Memory Loss    FAMILY HISTORY   Musculoskeleta    Redical Condition(5):   Father    Mother   Sibling(s)    Maternal Grandparent(s)    Paternal Grandparent(s)    Paternal Grandparent(s)    Paternal Grandparent(s)    Paternal Grandparent(s)    Paternal Grandparent(s)	What problem(s) are you her	re for today?						
Please check if you have been experiencing any of the following:	Date of Onset:							
CONSTITUTION EYES GASTROINTESTINAL ENDO/HEME/ALL    Chills	Symptoms							
Chills	Please check if you have been experiencing any of the following:							
Weight Loss	CONSTITUTION	EYES GASTROINTESTINAL ENDO/HEME/ALL						
Fatigue	☐ Chills	☐ Blurred Vision	☐ Heartburn	☐ Easy Bruising				
Sweating or Perspiration   Tunnel Vision   Addominal Pain   Dizziness	☐ Weight Loss	☐ Double Vision	□ Nausea	☐ Allergies				
Weakness   Blackouts   Diarrhea   Dizziness     SKIN	☐ Fatigue	☐ Sensitive to Light	☐ Vomiting	☐ Excessive Thirst				
Skin	☐ Sweating or Perspiration	☐ Tunnel Vision	☐ Abdominal Pain	NEUROLOGICAL				
Rash	☐ Weakness	☐ Blackouts	☐ Diarrhea	□ Dizziness				
Itching	SKIN	☐ Spots in Vision	☐ Constipation	☐ Tingling				
CARDIOVASCULAR   Hearing Loss   GENITOURINARY   Speech Change   Chest Pain   Ringing in the Ears   Palipitations or Flutters   Loss of Smell   Urgency   Seizures   Loss of Consciousness   Leg Swelling   Loss of Taste   Urinary Frequency   Loss of Consciousness   Leg Pain while Walking   Congestion   Blood in Urine   PSYCHIATRIC   PSYCHIATRIC   Depression   When Lying Down   RESPIRATORY   MUSCULOSKELETAL   Suicidal Ideas   Short of Breath   Cough   Muscle Pain   Substance Abuse   Hallucinations   Sputum Production   Back Pain   Insomnia   Insomnia   Memory Loss   Family Member:   Family HISTORY   Medical Condition(s):  Family Member:   Medical Condition(s):   Father   Mother   Sibling(s)   Maternal Grandparent(s)   Paternal Grandparent(s)   Paternal Grandparent(s)   Family Member   Medical Condition   Memory Loss   Medical Condition(s):   Father   Mother   Medical Condition(s):   Memory Loss   Memory	□ Rash	HENT	☐ Blood in Stool	☐ Tremor				
Chest Pain	☐ Itching	☐ Headaches	☐ Black Stook	☐ Sensory Change				
Palpitations or Flutters   Loss of Smell   Urgency   Seizures   Loss of Consciousness   Leg Swelling   Loss of Taste   Urinary Frequency   Loss of Consciousness   PSYCHIATRIC   Depression   Depression   Depression   Depression   Depression   Depression   Depression   Suicidal Ideas   Suicidal	CARDIOVASCULAR	☐ Hearing Loss	GENITOURINARY	☐ Speech Change				
□ Leg Swelling □ Leg Pain while Walking □ Shortness of Breath When Lying Down □ Waking from Sleep Short of Breath Short of Breath □ Coughing up Blood □ Neck Pain □ Short of Breath □ Hallucinations □ Nervous/Anxious □ Insomnia □ Nemory Loss  FAMILY HISTORY  Please indicate if any of your family members have or had any medical conditions.  Example: high blood pressure, enlarged heart, sudden death, liver, lung problems, cancer, diabetes, thyroid  Family Member:  Medical Condition(s):  Father  Mother Sibling(s)  Maternal Grandparent(s)  Paternal Grandparent(s)  Paternal Grandparent(s)  Aunt Uncle Children	☐ Chest Pain	☐ Ringing in the Ears	☐ Painful Urination	☐ Focal Weakness				
□ Leg Pain while Walking □ Shortness of Breath When Lying Down □ Waking from Sleep Short of Breath □ Cough □ Coughing up Blood □ Neck Pain □ Short of Breath □ Short of Breath □ Wheezing □ Short of Breath □ Wheezing □ FAMILY HISTORY  Please indicate if any of your family members have or had any medical conditions.  Example: high blood pressure, enlarged heart, sudden death, liver, lung problems, cancer, diabetes, thyroid  Father  Mother Sibling(s)  Maternal Grandparent(s)  Paternal Grandparent(s)  Aunt Uncle Children	☐ Palpitations or Flutters	☐ Loss of Smell	☐ Urgency	☐ Seizures				
Shortness of Breath When Lying Down RESPIRATORY MUSCULOSKELETAL Suicidal Ideas Suicidal Ideas Substance Abuse Short of Breath Sputum Production Sputum Production Short of Breath Short of Breath Short of Breath Short of Breath Meezing Family HISTORY  Please indicate if any of your family members have or had any medical conditions.  Example: high blood pressure, enlarged heart, sudden death, liver, lung problems, cancer, diabetes, thyroid Family Member: Medical Condition(s):  Father Mother Sibling(s) Maternal Grandparent(s) Paternal Grandparent(s) Aunt Uncle Children	☐ Leg Swelling	☐ Loss of Taste	☐ Urinary Frequency	☐ Loss of Consciousness				
When Lying Down  RESPIRATORY    Waking from Sleep   Short of Breath   Coughing up Blood   Neck Pain   Nervous/Anxious   Hallucinations   Nervous/Anxious   N	☐ Leg Pain while Walking	☐ Congestion	☐ Blood in Urine	PSYCHIATRIC				
Waking from Sleep   Cough   Muscle Pain   Substance Abuse   Hallucinations   Hallucinations   Sputum Production   Back Pain   Insomnia   Insomnia   Memory Loss   Hallucinations   Memory Loss   Memory Loss	☐ Shortness of Breath	☐ Sore Throat	☐ Flank Pain	☐ Depression				
Short of Breath	When Lying Down	RESPIRATORY	MUSCULOSKELETAL	☐ Suicidal Ideas				
Sputum Production Back Pain Nervous/Anxious Memory Loss    Short of Breath Short of Breath Memory Loss Memory Loss Memory Loss    Family History	☐ Waking from Sleep	☐ Cough	☐ Muscle Pain	☐ Substance Abuse				
Short of Breath   Joint Pain   Insomnia   Memory Loss    FAMILY HISTORY  Please indicate if any of your family members have or had any medical conditions.  Example: high blood pressure, enlarged heart, sudden death, liver, lung problems, cancer, diabetes, thyroid  Family Member:   Medical Condition(s):  Father   Mother   Sibling(s)   Maternal Grandparent(s)   Paternal Grandparent(s)   Aunt   Uncle   Children	Short of Breath	☐ Coughing up Blood	☐ Neck Pain	☐ Hallucinations				
FAMILY HISTORY  Please indicate if any of your family members have or had any medical conditions.  Example: high blood pressure, enlarged heart, sudden death, liver, lung problems, cancer, diabetes, thyroid  Family Member: Medical Condition(s):  Father Mother Sibling(s)  Maternal Grandparent(s)  Paternal Grandparent(s)  Aunt Uncle Children		☐ Sputum Production	☐ Back Pain	☐ Nervous/Anxious				
FAMILY HISTORY  Please indicate if any of your family members have or had any medical conditions.  Example: high blood pressure, enlarged heart, sudden death, liver, lung problems, cancer, diabetes, thyroid  Family Member: Medical Condition(s):  Father  Mother  Sibling(s)  Maternal Grandparent(s)  Paternal Grandparent(s)  Aunt  Uncle  Children		☐ Short of Breath	☐ Joint Pain	☐ Insomnia				
Please indicate if any of your family members have or had any medical conditions.  Example: high blood pressure, enlarged heart, sudden death, liver, lung problems, cancer, diabetes, thyroid  Family Member: Medical Condition(s):  Father  Mother  Sibling(s)  Maternal Grandparent(s)  Paternal Grandparent(s)  Aunt  Uncle  Children		☐ Wheezing	☐ Falls	☐ Memory Loss				
Please indicate if any of your family members have or had any medical conditions.  Example: high blood pressure, enlarged heart, sudden death, liver, lung problems, cancer, diabetes, thyroid  Family Member: Medical Condition(s):  Father  Mother  Sibling(s)  Maternal Grandparent(s)  Paternal Grandparent(s)  Aunt  Uncle  Children		-						
Please indicate if any of your family members have or had any medical conditions.  Example: high blood pressure, enlarged heart, sudden death, liver, lung problems, cancer, diabetes, thyroid  Family Member: Medical Condition(s):  Father  Mother  Sibling(s)  Maternal Grandparent(s)  Paternal Grandparent(s)  Aunt  Uncle  Children		FAMIL	Y HISTORY					
Family Member: Medical Condition(s):  Father  Mother  Sibling(s)  Maternal Grandparent(s)  Paternal Grandparent(s)  Aunt  Uncle  Children	Please ind	icate if any of your family me	mbers have or had any medic	cal conditions.				
Father  Mother  Sibling(s)  Maternal Grandparent(s)  Paternal Grandparent(s)  Aunt  Uncle  Children								
Mother Sibling(s)  Maternal Grandparent(s)  Paternal Grandparent(s)  Aunt Uncle Children	Family Member:	Medical Condition(s):						
Sibling(s)  Maternal Grandparent(s)  Paternal Grandparent(s)  Aunt  Uncle  Children								
Maternal Grandparent(s) Paternal Grandparent(s)  Aunt Uncle Children								
Paternal Grandparent(s) Aunt Uncle Children	5.							
Aunt Uncle Children	• • • •							
Uncle Children								
Children								
——————————————————————————————————————								
☐ Check here if adopted and do not know your family history								

			SOCIA	L HIST	ORY				
Please answer the following questions about your home support systems.									
With whom do you live?									
Any difficulty affording housi	ng, food,	medications?	)						
Who is your primary support	system?								
Who is your primary support	system f	or health need	ds?						
Number of children:				Ag	es:				
			HEAL	TH HIS	TORY				
Implantable Devices									
Do you					If yes, p	please specify	/ manufacturer an	d managing MD:	
have a pacemaker?		[	□ Yes	□ No					
have a Cardioverter-Defib	rillator (I	CD)? [	□ Yes	□ No					
have a Loop Recorder?		[	□ Yes	□ No					
<b>Coronary Risk Factors</b>									
If you have had any of the fo	ollowing,	please write i	n the y	ear it w	as identi	fied.			
Hypertension (High E	Blood Pre	ssure)				Family History of Heart Disease			
Diabetes						Obstructiv	Obstructive Sleep Apnea		
Abnormal / High Cho	lesterol					CPAP Machine			
Peripheral Artery Dis	ease (car	otid, legs)				Current or	Former Smoker		
Cardiovascular									
If you have had any of the fo	ollowing,	please write i	n the y	ear it w	as identi	fied.			
Coronary Artery Dise	ase					Congestive	e Heart Failure (w	eak heart muscle)	
Heart Attack						Deep Vein	Thrombosis (DVT	, blood clot in leg	
Enlarged Heart						Carotid Artery Disease / Stenosis			
Stroke or TIA (mini st	roke)					Pulmonary Embolism (blood clot in lung)			
Heart Murmur						Aneurysm			
Heart Valve Disease						Arrhythmi	a (abnormal rhyth	nm)	
Peripheral Artery Dis	ease (blo	ckages in leg a	arteries	s)					
Cardiac Procedures/Diagno	stic Test	ing							
If you have had any of the fo	llowing, p	olease write in	the ye	ar it wa	s comple	ted.			
Heart Catheterization					Heart Imaging (CT/MRI/ECHO/Calcium Score				
Heart/Leg or other Angioplasty/Stent Placement						Heart Monitor (EKG/Extended Monitor)			
Ablation Procedure						Other:			
Lifestyle									
Do you use tobacco?	☐ Yes	☐ Never	□F	ormerl	y, quit da	te:	Amount per	For how long?	
	Type:	☐ Cigarettes	s 🗆 E	lectron	ic Cigare	ttes	day:		
	☐ Cigars ☐ Pipes								
		☐ Snuff	•			)			
Do you use recreational	☐ Yes	□ Never			, quit da		Amount per	For how long?	
drugs?	Туре:	☐ Marijuana		☐ Methamphetamine			day:		
	☐ Cocaine			☐ Heroin					
		☐ Other							
	Ī						l		

Diet							
Do you drink alcohol?	☐ Yes	□ Never	☐ Formerly,	quit date:		Amount per	For how long?
	Type:	□ Beer	☐ Wine			day:	
		☐ Spirits					
Do you drink caffeine?	☐ Yes	☐ Never	☐ Formerly,	quit date:		Amount per	For how long?
	Type:	☐ Coffee	☐ Soda			day:	
		□ Tea					
On a special diet?	☐ Yes	□ No	If yes, what	type?			
Activity	Г_						
Do you exercise?	□ No	<u> </u>	sically Unable	☐ Occasionally			Competitively
At what intensity?	☐ Light	□ Mo	derate	☐ High		Vigorous	☐ Extreme
Please list  Type of Exe	reiso		Нош тап	y days per week?		How many minu	itos por day?
Type of Like	TCISE		TIOW IIIaii	y days per week:		110W IIIany IIIin	ates per day:
If you compete, where and v	vhen is yo	ur next com	petition?				
If you climb, where and whe	n is your r	next climb?					
If you are following a particular exercise program, please attach this program separately.							
,,, y		, ,	<u></u>			<i>,</i>	
				QUESTIONNAIRE			
Please answer the following	g questioi	ns about yo	ur monthly m	enstrual cycle.			
First Day	of your la	st period:					
How many days does your	period us	ually last? _					
How many days is	your perio	od heavy?					
What age were you when yo	our period	s started?					
During your period, do you						Yes	No
		tamnons w	ithin 1-2 hours	:?			
soak through one or more pads or tampons within 1-2 hours?						_	
need to double up on pads to control your menstrual flow?					Ш		
need to change your pads or tampons during the night?							
have periods lasting more than 7 days?							
experience blood clots the size of a quarter or larger?							
experience heavy bleeding that keeps you from the things you would do normally?							
have constant pain in the lower part of the stomach?							