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?
Relevant Surgeries and Procedures			
Surgery / Procedure:	Location:	Date:	Name of Surgeon / Specialist:
Relevant Hospital and Emergency Room Visits			
Date(s):	Location:	How long?	Seen for?

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

CARDIOVASCULAR

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

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

NEUROLOGICAL

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

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: 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	
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:

HEALTH HISTORY

Implantable Devices

Do you …		If yes, please specify manufacturer and managing MD:
have a pacemaker?	☐ Yes ☐ No	
have a Cardioverter-Defibrillator (ICD)?	☐ Yes ☐ No	
have a Loop Recorder?	☐ Yes ☐ No	

Coronary Risk Factors

If you have had any of the following, please write in the year it was identified.

	Hypertension (High Blood Pressure)		Family History of Heart Disease
	Diabetes		Obstructive Sleep Apnea
	Abnormal / High Cholesterol		CPAP Machine
	Peripheral Artery Disease (carotid, legs)		Current or Former Smoker

Cardiovascular

If you have had any of the following, please write in the year it was identified.

	Coronary Artery Disease		Congestive Heart Failure (weak heart muscle)
	Heart Attack		Deep Vein Thrombosis (DVT, blood clot in leg)
	Enlarged Heart		Carotid Artery Disease / Stenosis
	Stroke or TIA (mini stroke)		Pulmonary Embolism (blood clot in lung)
	Heart Murmur		Aneurysm
	Heart Valve Disease		Arrhythmia (abnormal rhythm)
	Peripheral Artery Disease (blockages in leg arteries)		

Cardiac Procedures/Diagnostic Testing

If you have had any of the following, please write in the year it was completed.

	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	☐ Formerly, quit date:	Amount per day:	For how long?
	Type:	☐ Cigarettes	☐ Electronic Cigarettes		
		☐ Cigars	☐ Pipes		
		☐ Snuff	☐ Chewing Tobacco		
Do you use recreational drugs?	☐ Yes	☐ Never	☐ Formerly, quit date:	Amount per day:	For how long?
	Type:	☐ Marijuana	☐ Methamphetamine		
		☐ Cocaine	☐ Heroin		
		☐ Other			

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?

If you compete, where and when is your next competition?	
If you climb, where and when is your next climb?	

If you are following a particular exercise program, please attach this program separately.

MENSTRUAL HEALTH QUESTIONNAIRE

Please answer the following questions about your monthly menstrual cycle.

First Day of your last period: _____

How many days does your period usually last? _____

How many days is your period heavy? _____

What age were you when your periods started? _____

During your period, do you …	**Yes**	**No**
soak through one or more pads or tampons within 1-2 hours?	☐	☐
need to double up on pads to control your menstrual flow?	☐	☐
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?	☐	☐