Health History Form
The Hope Chest Exercise and Dragon Boat Program

* **Please be advised all information is kept strictly confidential**

Today's Date: _____

Participants Name: _____
Last First
Address: _____

_____

Email: _____

Phone: H:_____C:_____W:_____

Emergency Contact Name: _____Relationship_____

Emergency Contact Number: H:_____C:_____W:_____

Do you have physician's approval to exercise? Yes or no (circle one)

Breast Cancer History:

1. Date of Diagnosis:_____
2. Please Circle any/all treatments: Surgery Chemotherapy Radiation
3. Did Surgery or radiation occur on: Right Side Left Side Both Sides (circle one)
4. If you had surgery was the procedure: Lumpectomy Mastectomy (circle one)
5. Are you currently on any breast cancer related medications? Please list:
   a. _____
   b. _____
6. Are you experiencing any discomfort or limitations due to your treatment or medications? Please explain:

---

7. Have you exercised since your treatment? Yes No (circle one)

   If yes, when did you begin to exercise? _____

8. General History:

a. Please check any of the following conditions that apply to your health:

	Arthritis		Heart Problems	Hip Replacement R/L
	Asthma		High Blood Pressure	Knee Replacement R/L
	Diabetes		High Cholesterol	Other_____
	Epilepsy		Stroke	

b. Do you have pain or discomfort in any of these areas? Please check that apply

	Neck		Lower Back
	Elbows		Knees
	Wrists		Shoulders
	Hips		Upper Back

Please give further description:

_____

_____

_____

c. Please list any over the counter or prescription medications you are taking, including any supplements:

Supplements:

_____
_____
_____
_____

Medications:

_____
_____
_____

d. Are you currently undergoing treatment from any of the following? (please circle)

Physical Therapist Chiropractor Massage Therapist