

# Parkinson's Exercise Class Medical History Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

Phone# \_\_\_\_\_ Age \_\_\_\_\_ Onset Date of Parkinson's Disease \_\_\_\_\_

Address \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone # \_\_\_\_\_

Physician Name \_\_\_\_\_ Phone# \_\_\_\_\_

Have you ever been diagnosed as having any of the following conditions?

- |  |                |                     |
|--|----------------|---------------------|
| 1. Heart Attack                            | Yes ___ No ___ | Date of Onset _____ |
| 2. Transient Ischemic Attack or Stroke     | Yes ___ No ___ | Date of Onset _____ |
| 3. Angina (chest pain)                     | Yes ___ No ___ | Date of Onset _____ |
| 4. High Blood Pressure                     | Yes ___ No ___ | Date of Onset _____ |
| 5. Diabetes                                | Yes ___ No ___ | Date of Onset _____ |
| 6. Respiratory Disease                     | Yes ___ No ___ | Date of Onset _____ |
| 7. Polio/Post Polio syndrome               | Yes ___ No ___ | Date of Onset _____ |
| 8. Seizures                                | Yes ___ No ___ | Date of Onset _____ |
| 9. Osteoporosis                            | Yes ___ No ___ | Date of Onset _____ |
| 10. Osteoarthritis or Rheumatoid Arthritis | Yes ___ No ___ | Date of Onset _____ |
| 11. Uncorrected visual problems            | Yes ___ No ___ | Date of Onset _____ |
| 12. Inner Ear Problems                     | Yes ___ No ___ | Date of Onset _____ |
| 13. Ataxia or other movement disorders     | Yes ___ No ___ | Date of Onset _____ |
| 14. Chemical dependency                    | Yes ___ No ___ | Date of Onset _____ |
| 15. Depression                             | Yes ___ No ___ | Date of Onset _____ |
| 16. Cancer                                 | Yes ___ No ___ | Date of Onset _____ |
| 17. Joint Replacement                      | Yes ___ No ___ | Date of Onset _____ |
| 18. Spine problems or surgeries            | Yes ___ No ___ | Date of Onset _____ |
| 19. Cognitive disorder                     | Yes ___ No ___ | Date of Onset _____ |
| 20. Any other type of health problem       | Yes ___ No ___ | Date of Onset _____ |

Do you use an assistive device for walking? Yes \_\_\_ No \_\_\_ What type \_\_\_\_\_

Have you required emergency medical care or hospitalization in the last year? Yes \_\_\_ No \_\_\_  
If yes please explain why \_\_\_\_\_

Have you had any falls within the past year? Yes \_\_\_ No \_\_\_ If yes how many? \_\_\_\_\_

Do you currently require caregiver assistance to carry out daily activities? Yes \_\_\_ No \_\_\_

Please attach a current list of medications and the condition they are treating.