

F.I.T. Together Health History Questionnaire

We are dedicated to protecting your privacy. The information you provide on this form will be kept completely confidential and will be shared only with the class instructors.

Name: _____

Phone Number: _____

Emergency Contact: _____

Cancer type: _____ Date of diagnosis: _____

Oncologist: _____ Primary Care Physician: _____

Treatment Information

- 1) Did you have surgery for cancer? Yes No

Date of surgery: _____ Site of Surgery: _____

Impairments from surgery (if any): _____

- 2) Have you had any other surgeries not related to cancer (e.g. knee replacement)? Yes No

Date of surgery: _____ Site of Surgery: _____

Impairments from surgery (if any): _____

- 3) Did you have chemotherapy? Yes No

Date of completion: _____ Name of chemotherapy: _____

Do you have persistent side effects from chemotherapy? Yes No

Please list any symptom(s) that is bothering you now that you believe could be related to your prior chemotherapy (e.g. numbness in fingers and toes, pain, depression): _____

- 4) Did you have radiation therapy? Yes No

Site of radiation: _____ Date of radiation completion: _____

Impairments or symptoms from radiation (if any): _____

- 5) Are you taking any medications currently related to your cancer treatment (e.g., antihormonal therapy for breast cancer [tamoxifen])? Yes No

Name of medication: _____

Please list any symptom you have now that you believe is related to your medication: _____

- 6) Are you taking any other medications unrelated to your cancer? Yes No
Please provide the names as best as you can remember them and what they are for

- 7) Please indicate if you have any of the following symptoms and describe, as necessary.

- Fatigue: _____
 - Depression: _____
 - Anxiety: _____
 - Difficulty sleeping: _____
 - Weight gain or loss: _____
 - Change in appetite: _____
 - Pain: _____
 - Shortness of breath: _____
 - Edema: _____
 - Joint stiffness or pain (include any joint replacements or surgeries): _____
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- Fractures: _____
 - Myalgias (muscle pain): _____
 - Muscle weakness: _____
 - Lymphedema: _____
 - Neuropathy: _____
 - Other: _____

- 8) Please indicate if you have ever had the following health conditions and describe if necessary:

- Hypertension (high blood pressure): _____
- High cholesterol: _____
- Heart attack: _____
- Congestive heart failure: _____
- Stroke: _____
- DVT (blood clot): _____
- Diabetes: _____
- Arthritis: _____
- Osteoporosis: _____
- Other: _____

Is there anything else that you want the exercise instructor to know about you?
