UMHB EXSS
HUMAN PERFORMANCE LABORATORY
Medical History Form

Directions. The purpose of this questionnaire is to enable the staff of the Human Performance Laboratory to evaluate your health. Please answer the following questions to the best of your knowledge. All information given is **CONFIDENTIAL** as described in the **Informed Consent Statement.**

Name: ____ **Age** _____ **Date of Birth** ____________

Name and Phone Number of Your Physician: ____

Have you ever been clinically diagnosed with carbohydrate malabsorption or intolerance syndrome (e.g., Lactose Intolerance)? If yes, when? ____
____

If yes, are you presently taking prescription medication to treat your condition? If yes, please list the type and frequency that you consume the medication you have been prescribed.____
____
____

If not diagnosed by a physician for dairy or lactose sensitivity, do you believe yourself to be dairy or lactose sensitive? If yes, please explain. ____
____
____

In response to consuming carbohydrate-containing food, do you experience any of the following: (circle all that apply)

Abdominal Pain/Discomfort	Bloating and Abdominal Distention
Diarrhea	Constipation
Nausea	Gas or Belching

Have you ever been clinically diagnosed with small intestinal bacterial overgrowth (SIBO)? If yes, when? ____

If yes, are you presently taking prescription medication to treat your condition? If yes, please list the type and frequency that you consume the medication you have been prescribed. ____

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Please list any over-the-counter medications or dietary supplements you take as treatment for dairy or lactose sensitivity. Include the type and frequency that you consume the OTC or supplement. ____
____
____
____

Are you currently adhering to an exclusion or avoidance diet (e.g., low-FODMAP, dairy free, etc.) to preventatively reduce bloating, gas, and similar gastrointestinal adverse effects? If yes, please explain. ____
____
____
____

Have you ever had a Gastric Bypass or Stomach Stapling surgery? If so, when? ______________
____

Within the past six (6) months, have you had a Gastrointestinal Cleanse? If so, when? ________
____

Are you presently taking, or have you recently discontinued taking prescription antibiotics. If yes, please list the type and frequency that you consume the medication you have been prescribed. ____
____
____

Do you have a history of drug or alcohol abuse? If yes, please explain. _____________________
____
____

Do you have a history of binge drinking? If yes, please explain. ____________________________
____
____

Do you have a history of morphine or pain medication use? If yes, please explain. ___________
____
____

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CIRCLE ANY GASTROINTESTINAL SYMPTOMS WHICH YOU MAY HAVE:

Abdominal Pain or Cramps

Bloating

Rectal Gas Excretion (passing gas)

Diarrhea

Difficulty or Painful Swallowing

Heartburn/Indigestion

Vomiting/Nausea

Black or bloody stools

Constipation

Hemorrhoids

Rectal Bleeding

Change in Bowel Habits

Eating Disorder

Loss of Appetite or Weight

Distress from Spicy or Fatty Foods

Jaundice (yellow eyes/skin)

Light Colored Stool

In the past 12 months, have you experienced abdominal discomfort or pain for at least 12 or more weeks total (doesn't need to be continuous)? YES/NO (circle one)

If 'yes', then:

Was the discomfort or pain relieved when you have a bowel movement? YES/NO

When it began, did you have a change in the frequency of stool? YES/NO

When it began, was there a change in the form (appearance) of stool? YES/NO

PERSONAL HEALTH HISTORY:

Surgeries
(list the type of operation, where, & when)

____
____
____
____
____
____

Medical History
(list illness or condition and date of onset)

____
____
____
____
____
____

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CURRENT SYMPTOMS: (Please circle all symptoms that are present)

General	Fever or chills, sweats, fatigue, weakness, lack of energy, bleeding tendency, weight gain or loss
Eyes, Ears, Nose, & Throat	Eye problems, ear problems, hoarseness, sore throat, sinus problems, mouth sores
Skin	Rash, flaking, itching, burning
Heart	Chest pain, high BP, murmur, dizziness, fainting, ankle/leg swelling, poor circulation, palpitations
Lungs	Chronic cough, shortness of breath, spitting blood, asthma, bronchitis, emphysema
Endocrine	Diabetes, thyroid disease, thirst
Genitourinary	Frequent urination, painful urination, urgent urination, blood in urine, dark urine, venereal disease
Joints	Back pain, arthritis, joint or muscle pains
Neurological/Psychiatric	Severe headaches, poor sleep, sadness/depression, crying spells, nervousness, seizures
Allergy/Immune	Immune deficiency, hay fever

Explain any of the above (if needed): ____
____
____
____

ALLERGIES: (list all known allergies and reactions)

Allergy	**Reaction**
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Allergies to Latex? YES/NO (circle one)

If yes, explain: ____

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CURRENT MEDICATIONS: (list all known allergies and reactions)

Name	Dose & Frequency	Reason for Use

Do you know of any medical condition that may make it dangerous or unwise for you to participate in this study? YES/NO (circle one) If yes, please explain: ____________________________
____
____
____

RECOMMENDATION FOR PARTICIPATION: (For Lab Staff Use ONLY)

____ No exclusion criteria presented. Subject is ***cleared*** to participate in the study.

____ Exclusion criteria is/are present. Subject is ***not cleared*** to participate in the study.

Investigator Signature: ____ Date: _________________

Investigator Name (printed): ____________________________________