MEDICAL HISTORY FORM

Study Title: Adult Bathing Surface Slip Resistance (II)

Date: _____ Participant Code Number (ID): _____

Sex: ☐ Male ☐ Female Age: _____ Height (ft/in): _____ Weight (lb): _____

Other Study Specific Measurement(s): _____

In Case of an Emergency, Contact:

GENERAL INFORMATION		
Do you experience: Shortness of breath Dizziness Headache Easily fatigued Pain in arm, shoulder or chest	☐ NO ☐ NO ☐ NO ☐ NO ☐ NO	☐ YES ☐ YES ☐ YES ☐ YES ☐ YES
Are you able to walk 25 feet?	☐ NO	☐ YES
Do you require an assistive device when walking (i.e. cane, walker)	☐ NO	☐ YES
Have you had surgery in the past 6 weeks? If yes, when?	☐ NO	☐ YES
Do you have a mental, cardiac, respiratory and neuro-degenerative disorder ?	☐ NO	☐ YES