Medical History Questionnaire

Name: _____ Address: _____

Phone Number: _____ Cell:_____

Date of Birth: _____ Height_____Weight_____

Physician's Name & Phone: _____

Date of Last Physical Exam: _____

Have you ever suffered from or been diagnosed with: **(please check if applies to you)**

☐ Heart Attack	☐ Pacemaker	☐ Aneurysm
☐ Heart Disease	☐ Cardiac Surgery	☐ Angina Pectoris
☐ Coronary Bypass	☐ Stroke	☐ Embolism

Please check if you have:

☐ High Blood Pressure >160/90 ☐ High Cholesterol > 220 ☐ I don't know

Smoker? If so, give details_____

Family history of coronary or other conditions: give details_____

_____

Are you currently taking medication on a regular basis? _____ If so, please list _____

_____

Do you have an injuries or orthopedic problems (bursitis, back pain, knee pain, etc.)? _____

_____

Are you currently involved in a regular exercise program? If so, how many days per week? How long is each exercise session?_____

What are your goals within this program? _____

_____

_____

Consent Form:
I acknowledge to the best of my ability, that I am in good health and have no known medical problem that would restrict my ability to participate in this exercise program.

Signature_____ ____ Print_____ Date_____