Freedom House for Women, Inc.

Medical History Form

A. Name: ______________________ Date: ______________________

B. Telephone: ______________________ Date of Birth: ______________

C. Age: ________ Height: __________ Weight: ________

D. In Case of Emergency Contact: ______________________ Relationship: __________

E. Address: ______________________________ Phone: ______________

F. Physician: ____

G. Address: ______________________________ Phone: ______________

H. Are you currently under a doctor's care: Yes ☐ No ☐

I. If yes, explain: ______________________________________

J. Date of your last physical examination? ______________________

K. Have you ever had an exercise stress test: Yes ☐ No ☐ Don't Know ☐

L. If yes, were the results: Normal ☐ Abnormal ☐

M. Do you take any medications on a regular basis? Yes ☐ No ☐

N. If yes, please list medications and reasons for taking: ______________________

O. Have you recently been hospitalized? Yes ☐ No ☐

- If yes, explain: ____

Please check yes or no if you have any of the following medical conditions?

Do you smoke? Yes ☐ No ☐	Are you pregnant? Yes ☐ No ☐	High cholesterol? Yes ☐ No ☐	Diabetes? Yes ☐ No ☐
High blood pressure? Yes ☐ No ☐	Heart disease? Yes ☐ No ☐	Heart murmur? Yes ☐ No ☐	Chest pain with exertion? Yes ☐ No ☐
Irregular heartbeat or palpitations? Yes ☐ No ☐	Lightheadedness or fainting? Yes ☐ No ☐	Unusual shortness of breath? Yes ☐ No ☐	Cramping pains in legs or feet? Yes ☐ No ☐
Emphysema? Yes ☐ No ☐	Epilepsy? Yes ☐ No ☐	Asthma? Yes ☐ No ☐	Back pain? Yes ☐ No ☐
Muscle or joint pain? Yes ☐ No ☐	Headache or Migraines? Yes ☐ No	Seizures? Yes ☐ No	Other

Please list any current treatment or medications that you require:

1. ______________________ 2. ______________________

3. ______________________ 4. ______________________

For any medical condition answered yes, please provide additional Information:

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I acknowledge that to the best of my knowledge, the information listed is true regarding my health/medical information.

______________________________ ______________

Client Signature Date