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:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

_____ _____

Client Signature Date