MEDICAL HISTORY REVIEW FORM

Name: _____ Date: _____

Telephone: _____

Date of Birth:_____ Age: _____ Height: _____ Weight:_____

In Case of Emergency Contact: _____

Relationship:_____

Address: _____

Phone: _____

Physician: _____ Specialty: _____

Address: _____ Phone: _____

Are you currently under a doctor's care: [ ] Yes [ ] No

If yes, explain: _____

When was the last time you had a physical examination? _____

Have you ever had an exercise stress test: [ ] Yes [ ] No

If yes, were the results: Normal Abnormal

Do you take any medications on a regular basis? [ ] Yes [ ] No

If yes, please list medications and reasons for taking:

_____

Have you been recently hospitalized? [ ] Yes [ ] No

If yes, explain: _____

Do you smoke? [ ] Yes [ ] No

Are you pregnant? [ ] Yes [ ] No

Do you drink alcohol more than three times/week? [ ] Yes [ ] No

Is your stress level high? [ ] Yes [ ] No

Are you moderately active on most days of the week? [ ] Yes [ ] No

Do you have: High blood pressure? [ ] Yes [ ] No

High cholesterol? [ ] Yes [ ] No

Diabetes? [ ] Yes [ ] No

Have parents or siblings who, prior to age 55 had: [ ] Yes [ ] No

A heart attack? [ ] Yes [ ] No

A stroke?	[ ] Yes [ ] No
High blood pressure?	[ ] Yes [ ] No
High cholesterol?	[ ] Yes [ ] No
Known heart disease?	[ ] Yes [ ] No
Rheumatic heart disease?	[ ] Yes [ ] No
A heart murmur?	[ ] Yes [ ] No
Chest pain with exertion?	[ ] Yes [ ] No
Irregular heart beat or palpitations?	[ ] Yes [ ] No
Lightheadedness or do you faint?	[ ] Yes [ ] No
Unusual shortness of breath?	[ ] Yes [ ] No
Cramping pains in legs or feet?	[ ] Yes [ ] No
Emphysema?	[ ] Yes [ ] No
Other metabolic disorders (thyroid, kidney, etc.)?	[ ] Yes [ ] No
Epilepsy?	[ ] Yes [ ] No
Asthma?	[ ] Yes [ ] No
Back pain: upper, middle, lower?	[ ] Yes [ ] No
Other joint pain (explain on back of form)?	[ ] Yes [ ] No
Muscle pain or an injury (explain on back of Form)?	[ ] Yes [ ] No

To the best of my knowledge, the above information is true.

Print Name: _____

Sign Name: _____

Date: _____