MEDICAL HISTORY REVIEW FORM

Name: _____ Date: _____

Telephone: _____

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

In Case of Emergency Contact: _____Relationship: _____

Phone: _____

Physician: _____Specialty: _____

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
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
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
Asthma?	Yes	No
Back pain: upper, middle, lower?	Yes	No
Other joint pain (explain on back of form)?	Yes	No

Height: Weight:

Biceps (L/R): Thigh:

Hips: Waist:

Chest: Calves:

Goal – weight loss or gain? If so how much?

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

Print Name: _____

Sign Name: _____

Date: _____