Medical Information

What is your full name? ____

What is the present State of your general health?____

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Physician Name____

Phone____

Date of Birth____

Address____

Personal contact in case of an emergency? _________________________Phone______________________

Are you taking medication? Yes_______ No_______
If yes, what kinds?____

Are you now or have been pregnant within the past 3 months?__________________________________

Does your physician know you are participating in an exercise program?____________________________

Do you have now or history of? If yes please explain.

1.	A history of heart problems?	Yes_______	No_______
2.	High blood pressure?	Yes_______	No_______
3.	Difficulty with physical exercise?	Yes_______	No_______
4.	A chronic illness	Yes_______	No_______
5.	Advice from a physician not it exercise.	Yes_______	No_______
6.	Muscle, joint or back disorders that could	Yes_______	No_______
	be aggravated by physical activity?	Yes_______	No_______
7.	History of Surgeries? Explain Below	Yes_______	No_______
8.	History of lung problems?	Yes_______	No_______
9.	Diabetes?	Yes_______	No_______
10.	Cigarette—smoking habit?	Yes_______	No_______
11.	Obesity (more than 20lbs. overweight)?	Yes_______	No_______
12.	High blood cholesterol?	Yes_______	No_______
13.	History of heart problems in immediate family?	Yes_______	No_______

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What regular physical activity do you presently do?

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