Medical History Update

NAME: _____ TODAY'S DATE: _____

ADDRESS: _____

CITY/STATE/ZIP: _____ _____

PHONE: (W) _____ (H) _____

EMAIL: _____

EMERGENCY CONTACT: _____ PHONE: _____

PHYSICIAN: _____ PHONE: _____

DATE OF BIRTH:_____

On this form, a number of questions regarding your physical health are to be answered. Please answer every question as accurately as possible. Your responses will be held in strict confidence. Place a check next to the question to answer "YES." Leave blank if your answer is "NO."

Within the past year:

- ☐ Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
- ☐ Do you feel pain in your chest when you do physical activity?
- ☐ Have you had chest pain when you were not doing physical activity, if so, how long ago?

  _____
- ☐ Have you had a bone or joint problem that could be made worse by a change in your physical activity?
- ☐ Have you lost your balance because of dizziness or do you ever lose consciousness?
- ☐ Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
- ☐ Do you know of any other reason why you should not be participating in physical activity?
- ☐ Have you been diagnosed with any metabolic disease (thyroid, renal, liver)?
- ☐ Have you been diagnosed with Type 1 or 2 diabetes?
- ☐ Have you experienced any unaccustomed shortness of breath (perhaps during light exercise)?
- ☐ Have you experienced a rapid throbbing or fluttering of the heart?
- ☐ Have you been assessed as hypertensive on at least 2 occasions?
- ☐ Has your serum cholesterol been measured at greater than 240 mg/dl?
- ☐ Are you currently being treated for high blood pressure?

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