

For Office Use :	
Birthday	_____
Email	_____
Cons. Contact	_____
Thank you	_____
MD sent	_____

MEDICAL QUESTIONNAIRE

Name _____ Date _____

Address _____ City _____

State _____ Zip Code _____ E-mail _____

Telephone (H) _____ (W) _____

Date of Birth _____ Age _____ Height _____ Weight _____

Person to Call in Case of Emergency _____ Telephone _____

Physician's Name _____ Telephone _____

Physician's Address _____

- Do you have or are you being treated for:

High Blood Pressure	High Cholesterol	Diabetes
Heart Murmur	Abnormal EKG	Chest Pains
- Do you smoke? _____yes _____no If yes, how many packs per day? _____
 If former smoker, when did you quit? _____
- Are you pregnant? _____yes _____no
- Have you had any of the following during physical exertion?

Chest pain	Palpitations or rapid heart beats
Dizziness	Shortness of breath/difficulty breathing
- Have members of your immediate family (grandparents, parents, brothers or sisters) had heart disease (i.e. heart attack, angina or by-pass surgery) prior to age 55?
 _____yes_____no
 If yes, please list family member, age, and diagnosis _____
- Has a doctor ever told you that you have bone, joint, feet or back problems? ___ yes _____ no
 If yes, please list _____
- Are you taking any medications regularly? If yes, please list:

- Do you have any other medical history or special considerations we should be aware of when designing or supervising your exercise program? _____

PLEASE SIGN THE BACK OF THIS FORM

