Patient Medical History
And Personal Fitness Questionnaire

Personal History
Circle each as it applies to you. Have you ever had:

Condition			**Condition**		
Cardiac Pacemaker	Yes	No	Peripheral Vascular	Yes	No
Heart attack	Yes	No	Convulsions	Yes	No
Angina	Yes	No	Paralysis	Yes	No
Emphysema	Yes	No	Leg Cramps	Yes	No
High Blood Pressure	Yes	No	Headache	Yes	No
Diabetes	Yes	No	Depression	Yes	No
Stroke	Yes	No	Shortness of Breath	Yes	No
Severe Illness	Yes	No	Arm Pain	Yes	No
Blackouts	Yes	No	Low Blood Pressure	Yes	No
Gout	Yes	No	Indigestion/Ulcers	Yes	No
Nervousness	Yes	No	T.B.	Yes	No
Joint Problems	Yes	No	Asthma	Yes	No
Sleep Interference	Yes	No	Hernia	Yes	No
Chest Pain	Yes	No	Back Pain	Yes	No
Cancer	Yes	No	Allergy	Yes	No

For any condition in which a "Yes" was indicated please give dates and any details:

_____

Any other medical problems? If so, please describe:

_____

List your current medications: _____

Family History: **Circle each as it applies to a blood relative:**

Heart Attack	Yes	No	Tuberculosis	Yes	No
High Blood Pressure	Yes	No	Diabetes	Yes	No
Circulatory Disorder	Yes	No	Stroke	Yes	No
Heart Disease	Yes	No	Asthma	Yes	No

Height _____ Weight _____lbs.

Do you consume alcohol? Yes No If yes, how much?___ drinks per week/month(circle)

Do you smoke? Yes No If yes, how much?___ packs per day/week(circle)

I certify to the best of my knowledge the above answers are true and correct.

Patient Signature _____ Date _____