Health History and Medical Information

Please fill out this form completely.
All information submitted is CONFIDENTIAL. This info will not be shared or distributed in any way
Attach additional forms if necessary

GENERAL:
Name: _____ Social Security #:_____
Height:_____ Weight: _____
Male _____ Female: _____

Medical Coverage:
Health Insurance Provider: _____ Policy #_____
Policy Holders Name: _____

ALLERGIES: (medicine, food, insects, etc…)
Allergy Reaction/Severity Level Medication/Treatment Do you carry an EPI Kit?

_____
_____
_____

MEDICATIONS:
Drug Condition Dosage (amount & frequency)

_____
_____
_____

HEALTH HISTORY:

Have you at any time had:	YES	NO
1. Heart Problems, chest pains, stroke, etc...		
2. High Blood Pressure		
3. Chronic Illness or a chronic condition		
4. Difficulty with exercise		
5. Advice from a physician not to exercise		
6. Recent Surgery (last 12 months)		
7. Pregnancy (within last 3 months)		
8. Lung or breathing problems		
9. Muscle or joint injuries		
10. Back problems or injuries		
11. Do you smoke		
12. Ever been 40 or more pounds over ideal weight		
13. Ever had high blood cholesterol		
14. Family History of heart problems		
15. Any condition that may be aggravated by exercise		
16. Other afflictions or conditions		
17. Do you consider your life stressful		
18. Eating or sleeping problems recently		
19. Any contagious or blood bourne illnesses		

Please explain in detail any yes answers from above:

_____
_____
_____
_____

Please describe your current fitness/exercise activities including type, frequency, duration, and intensity:

_____
_____
_____
_____