Medical History Review Form

Name: ____________________________

Date: ____________________________

Telephone: ____________________________

Date of Birth: ____________________________

Age: ____________________________

Height: ____________________________

Weight: ____________________________

Emergency Contact Name: ____________________________

Emergency Contact Telephone Number: ____________________________

Emergency Contact Address: ____________________________

Emergency Contact Relationship To You: ____________________________

Physician Name: ____________________________

Physician Phone Number: ____________________________

Are You Currently Under A Doctors Care? **YES** **NO**

If Yes, Explain Why: ____

When Was The Last Time You Had A Physical Examination? _____/_____/________

Do You Take Any Medications On A Regular Basis? **YES** **NO**

If Yes, Which Medications And Reason For Taking Them: ______________________

____

Have You Been Recently Hospitalized? **YES** **NO**

If Yes, For What? ___________________________

Do You Smoke? **YES** **NO**

Do You Drink Alcohol? **YES** **NO**

How Do You Rate Your Emotional And Mental Stress Level **HIGH** **MEDIUM** **LOW**

Have You Ever Been Diagnosed With An Ongoing Health Ailment? **YES** **NO**

If Yes, What ailments? ____

Does Your Family Have A History Of Any Specific Medical Conditions? **YES** **NO**

If So, What Medical Conditions? ___________________________________

Do You Have Any Back Or Joint Pain? **YES** **NO**

If So, What areas of the Spine/Joints Do You Have Pain? __________________

____

Are There Any Limitations For You To Participate In A Physical Fitness Exercise Program **YES** **NO**

If Yes, What Are The Limitations On Certain Movements? __________________

____

To The Best Of My Knowledge, The Above Information Is True:

Print Name: ___________________________

Sign Name: ___________________________

Date: ___________________________