# 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: _____