MEDICAL HISTORY REVIEW FORM

Name: _____ Date: _____

Telephone: _____

Date of Birth:_____ Age: _____ Height: _____ Weight:_____

In Case of Emergency Contact: _____ Relationship:_____

Address: _____ Phone: _____

Physician: _____ Specialty: _____

Address: _____ Phone: _____

Are you currently under a doctor's care: Yes ☐ No ☐

If yes, explain: _____

When was the last time you had a physical examination? _____

Have you ever had an exercise stress test: Yes ☐ No ☐ Don't Know ☐

If yes, were the results: Normal ☐ Abnormal ☐

Do you take any medications on a regular basis? Yes ☐ No ☐

If yes, please list medications and reasons for taking: _____

Have you been recently hospitalized? Yes ☐ No ☐

If yes, explain: _____

Do you smoke? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐

Do you drink alcohol more than three times/week? Yes ☐ No ☐

Is your stress level high? Yes ☐ No ☐

Are you moderately active on most days of the week? Yes ☐ No ☐

Do you have:

High blood pressure? Yes ☐ No ☐

High cholesterol? Yes ☐ No ☐

Diabetes? Yes ☐ No ☐

Have parents or siblings who, prior to age 55 had: Yes ☐ No ☐

A heart attack? Yes ☐ No ☐

A stroke? Yes ☐ No ☐

High blood pressure? Yes ☐ No ☐