# 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 ☐

High cholesterol? Yes ☐ No ☐
Known heart disease? Yes ☐ No ☐
Rheumatic heart disease? Yes ☐ No ☐
A heart murmur? Yes ☐ No ☐
Chest pain with exertion? Yes ☐ No ☐
Irregular heart beat or palpitations? Yes ☐ No ☐
Lightheadedness or do you faint? Yes ☐ No ☐
Unusual shortness of breath? Yes ☐ No ☐
Cramping pains in legs or feet? Yes ☐ No ☐
Emphysema? Yes ☐ No ☐
Other metabolic disorders (thyroid, kidney, etc.)? Yes ☐ No ☐
Epilepsy? Yes ☐ No ☐
Asthma? Yes ☐ No ☐
Back pain: upper, middle, lower? Yes ☐ No ☐
Other joint pain (explain on back of form)? Yes ☐ No ☐
Muscle pain or an injury (explain on back of Form)? Yes ☐ No ☐

To the best of my knowledge, the above information is true.

Print Name: ___________________________________

Sign Name: ___________________________________

Date: ___________________________________