

Health and Medical History

Name: _____ Date: _____

CHECK ALL THOSE THAT APPLY:

- _____ Recent illness, hospitalization or surgical procedure
- _____ Heart attack, coronary bypass, cardiac surgery, stroke
- _____ Abnormal resting or stress ECG
- _____ Uneven, irregular, or skipped heart beats (including racing or fluttering)
- _____ Family history of coronary or other atherosclerotic disease
- _____ Diabetes type _____
- _____ High Blood Pressure
- _____ Phlebitis Emboli
- _____ Pulmonary Disease (asthma, emphysema, bronchitis)
- _____ Rheumatic Fever
- _____ Light Headedness or Fainting
- _____ Chest pain at rest or exertion
- _____ Unusual shortness of breath
- _____ Orthopedic problems (arthritis or bone, joint or muscle problems)
- _____ Emotional disorders
- _____ Medications
- _____ Drug Allergies
- _____ Smoking
- _____ Physical Inactivity
- _____ Alcohol Consumption

Comments (please include information pertaining to each checked item above, or any comments you deem necessary): _____
