

Medical History Questionnaire

General Information:

Name: _____

Address: _____

Phone (H) _____ (W) _____

Age: _____ Height: _____ Weight: _____ M ___ F ___

How long has it been since your last physical exam? _____

How long has it been since your last blood test? _____

Are you currently taking any medication? _____ If so, explain _____

Are you allergic to any foods or medications? _____ If so, explain _____

Do you have a family history of coronary heart disease, diabetes or high blood pressure? _____ If so, explain _____

Do you have any of the following?

- | | | |
|--------------------------|---------------------|----------|
| High Blood Pressure | Heart Attack | Diabetes |
| Chest Pain or Discomfort | Faintness | Asthma |
| Lightheadedness | Shortness of Breath | |

Are you pregnant? _____ Are you currently breast-feeding? _____

Please list any physical impairments (arthritis, muscle or joint problems, back pain, etc.)

Has your physician limited you in any way? _____ If so, explain _____

Do you currently smoke, or have you in the past? _____ Quit when? _____

Explain you present exercise (type and minutes per week) _____

What are your short term (6-8 weeks) and long term (1 year) goals? _____
