

Personal Medical History

Date: _____

Name: _____

Date of Birth _____ Age _____

Home Address: _____

Home Phone: _____

Other Phone: _____

Physician's Name and Address: _____

Person to Contact in Case of Emergency: _____

Referred By: _____

Date of Last Doctor's Visit: _____

Reason for visit? _____

Risk Factors:

Smoker	Past	Present
Hypertension		
Elevated Cholesterol		
Diabetes		
Type-A Behavior		
Stress		
Overweight		
Underweight		
Inactivity		

Trainer Notes

Current Health

Medications: Yes No

If yes, what kind _____

Asthma: Yes No

If yes, what type? _____

Heart History: Yes No

If yes, what type?

Surgery: Yes No

If yes, what type?

Arthritis: Yes No

If yes, what type?

Previous Injuries

Neck Problems: _____

Shoulder Problems: _____

Elbow Problems: _____

Wrist Problems: _____

Back Problems: _____

Hip Problems: _____

Knee Problems: _____

Spinal Trauma - Tendonitis - Bursitis - Broken Bones - Joint Injuries

Please explain in further detail items circled above: