Medical History

Date _____ **Full Name** _____

Gender _____ **Birth Date** _____

Please list any medications you are currently taking _____

_____

_____

Do you have or have you ever had any of the following conditions? If yes please describe

Heart Attack	Yes	No
Stroke	Yes	No
Chest Pain	Yes	No
Hypertension	Yes	No
Cancer	Yes	No
High Cholesterol	Yes	No
Diabetes	Yes	No
Arthritis	Yes	No
Hernia	Yes	No
Anemia	Yes	No
Obesity	Yes	No
Frequent Falls	Yes	No
Breathing Issues	Yes	No
Other	Yes	No

Please list any orthopedic conditions you have had or currently have

_____

_____

_____

Do you smoke? Please circle your choice. Yes No

Does your physician know you are starting a new exercise program? Please circle your choice. Yes No

Have you ever been advised by a healthcare professional not to exercise? Yes No

What are your health and wellness goals? For example, lose weight, sleep better, stress management.

_____

_____

_____

Do you have any concerns about starting an exercise program?

_____

_____

_____