Health/Medical Questionnaire

Name: _____ Date: _____

Address: _____ Age: _____ DOB: _____

_____ Sex: ____ Height: _____ Weight: _____

Home Phone: _____ Mobile phone: _____

Work Phone: _____

In case of emergency contact Mr./Mrs. _____ Phone #: _____

Personal Care Physician: _____

1. Have you had or do you have:

☐ heart attack	☐ thrombophlebitis	☐ rapid heart beats
☐ angina	☐ asthma	☐ high blood pressure

4. Do you have any conditions or past injuries which limit the range of motion of your muscles, joints, bones, back/neck or any other part of your body which may be aggravated by exercise?

Yes ☐ No ☐ If yes, please explain: _____

_____

5. Are you presently taking any medications on a regular basis? ☐ Yes ☐ No

If yes, please list all medications and dosages: attach separate sheet.

Are you allergic to any medications? ☐ Yes ☐ No
If yes, please list medications: _____

[redacted]

I have answered the preceding questions to the best of my ability. I understand that information gathered from this