



**Patient's Medical History:**

Today's Date: \_\_\_\_\_

Patient name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Height / weight: \_\_\_\_\_

Occupation: \_\_\_\_\_

Physician: \_\_\_\_\_ Date of last Physical Examination: \_\_\_\_\_

Physician's Clinic name and address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Check those that Apply:**

- \_\_\_\_\_ Recent illness, hospitalizations or surgical procedures
- \_\_\_\_\_ Heart Attack, coronary bypass, cardiac surgery
- \_\_\_\_\_ Abnormal resting or stress ECG
- \_\_\_\_\_ Uneven, irregular, or skipped heart beats (including a racing or fluttering heart)
- \_\_\_\_\_ High Cholesterol
- \_\_\_\_\_ High Blood Pressure
- \_\_\_\_\_ Diabetes
- \_\_\_\_\_ Blood Clots
- \_\_\_\_\_ Stroke
- \_\_\_\_\_ Pulmonary Disease (asthma, emphysema, bronchitis, other breathing problems)
- \_\_\_\_\_ Cancer
- \_\_\_\_\_ Pregnant - How many months along? \_\_\_\_\_
- \_\_\_\_\_ Ulcers
- \_\_\_\_\_ Orthopedic problems or injuries (arthritis or any other bone, joint, or muscle problems)
- \_\_\_\_\_ Emotional / psychological disorders (including stress, anxiety, or sleep disturbances)
- \_\_\_\_\_ Physical Inactivity
- \_\_\_\_\_ Smoking
- \_\_\_\_\_ Drinking Alcohol (include frequency, i.e. 1x daily, 3x weekly etc.) \_\_\_\_\_
- \_\_\_\_\_ Chemical Dependency
- \_\_\_\_\_ Medications: \_\_\_\_\_
- \_\_\_\_\_ Allergies: \_\_\_\_\_

Please List any other health problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate any current or past forms of exercise that you have participated in (including leisure activities):  
\_\_\_\_\_  
\_\_\_\_\_

Patient expected goals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_