Medical History Form

Name: ______________________________ Date: __________

Address: ______________________________ Phone: __________

Date of Birth: ______________________

Primary Physician's Name: ____________________ Phone: ____________

Person to contact in case of emergency: ____________ Phone: ____________

Do you now, or have you had in the past*:	Yes	No
1. History of heart disease, chest pain, or stroke?	❑	❑
2. History of heart problems in immediate family?	❑	❑
3. Hypertension (high blood pressure)?	❑	❑
4. High cholesterol level?	❑	❑
5. History of breathing or lung problems?	❑	❑
6. Diabetes or thyroid condition?	❑	❑
7. Any chronic illness or condition?	❑	❑
8. Advice from the physician not to exercise?	❑	❑
9. Recent surgery (12 months)?	❑	❑
10. Muscle, joint or back disorder or any previous injury still affecting you?	❑	❑
11. Hernia or any condition that may be aggravated by lifting weights?	❑	❑
12. Obesity (more than 20% over ideal body weight)?	❑	❑
13. A smoking habit?	❑	❑
14. Difficulty with physical exercise?	❑	❑

If you have answered yes to any of the above questions please explain:

____

____

____

* If a participant answers yes to any question 1-11, a medical release is recommended!