Medical History Questionnaire

Name: _____ Date:_____

Directions: If any of the following apply to you, please indicate by checking the appropriate area and filling in the needed information.

_____1. Are you currently taking any medication?
If yes, indicate what medication(s), length of time you have used and if prescribed by a physician or not. Include over the counter medications.

_____2 Do you smoke cigarettes or use tobacco products?
If yes, indicate how long and how much?

_____3. Are you taking any supplements? Vitamins, amino acids, herbs etc.
If yes, indicate what you are taking and how long. (May attach label).

4. Have you ever suffered from any of the following?

_____ heart attack	_____coronary artery disease
_____stroke	_____congestive heart failure
_____arthritis	_____cancer

5 Have you ever been diagnosed for any of the following? (Check if yes)

_____Diabetes Mellitus	_____Kidney problems	_____Pregnancy
_____Abnormal heart rate; murmur	_____Hypertension	_____Obesity
_____Chronic Infectious Diseases	_____Asthma	_____Anemia
_____Lower Back Pain	_____Joint problems	_____Dizziness
_____Abnormal metabolism	_____High Blood Cholesterol	_____Fainting
_____Muscle/skeletal problems	_____Other	

Please explain_____
_____

6. Is there a family history (parents, siblings) of the following before age 55?

_____ heart disease _____diabetes _____ obesity

7. Do you experience any of the following when you exercise?

_____ pain or discomfort in the chest region		_____shortness of breath
_____dizziness or fainting	_____skipped heart beats	_____leg pains

8. Is there any reason that you should not exercise?

9. Describe your current exercise program.

10. Do you have any muscle or skeletal problems or injuries? Please describe.

11. Have you had any lower back pain which lasted more than one week?

12. Are you/could you be currently pregnant?