

***Patient Medical History  
And Personal Fitness Questionnaire***

**Personal History**

Circle each as it applies to you. Have you ever had:

**Condition**

Cardiac Pacemaker	Yes	No
Heart attack	Yes	No
Angina	Yes	No
Emphysema	Yes	No
High Blood Pressure	Yes	No
Diabetes	Yes	No
Stroke	Yes	No
Severe Illness	Yes	No
Blackouts	Yes	No
Gout	Yes	No
Nervousness	Yes	No
Joint Problems	Yes	No
Sleep Interference	Yes	No
Chest Pain	Yes	No
Cancer	Yes	No

**Condition**

Peripheral Vascular	Yes	No
Convulsions	Yes	No
Paralysis	Yes	No
Leg Cramps	Yes	No
Headache	Yes	No
Depression	Yes	No
Shortness of Breath	Yes	No
Arm Pain	Yes	No
Low Blood Pressure	Yes	No
Indigestion/Ulcers	Yes	No
T.B.	Yes	No
Asthma	Yes	No
Hernia	Yes	No
Back Pain	Yes	No
Allergy	Yes	No

For any condition in which a “Yes” was indicated please give dates and any details:

Any other medical problems? If so, please describe:

List your current medications: \_\_\_\_\_

**Family History: Circle each as it applies to a blood relative:**

Heart Attack	Yes	No	Tuberculosis	Yes	No
High Blood Pressure	Yes	No	Diabetes	Yes	No
Circulatory Disorder	Yes	No	Stroke	Yes	No
Heart Disease	Yes	No	Asthma	Yes	No

Height \_\_\_\_\_ Weight \_\_\_\_\_lbs.

Do you consume alcohol? Yes No If yes, how much? \_\_\_ drinks per week/month(circle)  
Do you smoke? Yes No If yes, how much? \_\_\_ drinks per week/month(circle)

I certify to the best of my knowledge the above answers are true and correct.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_