Personal Medical History Survey

Name: _____

Local phone number: _____ **Email:** _____

Local address: _____

Today's date: _____ **Birthdate:** _____ **Age:** _____

1. Have you ever been diagnosed as having: (Check all that apply)

	Never	In past	Presently
A. Heart disease	_____	_____	_____
B. Rheumatic fever	_____	_____	_____
C. High blood pressure	_____	_____	_____
D. Other vascular disorders	_____	_____	_____
E. Diabetes or Low Blood Sugar	_____	_____	_____
F. Kidney disease	_____	_____	_____
G. Asthma	_____	_____	_____
H. Neurological Disorders (Parkinson's, MS, etc.)	_____	_____	_____
I. Chronic bronchitis	_____	_____	_____
J. Arthritis of the spine, hips, knees or ankles	_____	_____	_____
K. Osteoporosis	_____	_____	_____
L. Clinical depression	_____	_____	_____
M. Other:	_____	_____	_____

2. Please indicate any surgery that you have undergone and the approximate date(s):

_____

_____

_____

3. Please indicate recent (past 12 months) illnesses or major injuries that you have had. Also list approximate dates:

_____

_____

_____

4. Please list any and all medications (prescription and non-prescription) that you are presently taking:

	Medication	Dosage	Dosage per day
1			
2			
3			
4			
5			
6			

5. Do you smoke? _____ Packs per day? _____ Smokeless tobacco/Vape? _____

6. Describe your present exercise and/or physical activity program (the activity, amount per day, days per week, and the length of time you have been training at this level).

Activity	Minutes/day	Days/week	Weeks of participation

7. Do you have any other medical conditions or concerns which should be noted? If so, please describe: _____

_____

_____

Physician Name: _____

Physician Location: _____

TRAINER'S NOTES:

_____

_____

_____

_____

_____

_____