

YALETOWN FIT

MEDICAL HISTORY REVIEW FORM

Name: _____ Date: _____

Telephone: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Emergency Contact: _____ (optional) Relationship: _____

Address:(optional) _____ Phone: _____

Physician: (optional) _____ Specialty: _____

Physician's address: _____ Phone: _____

Are you currently under a doctor's care: Yes No

If yes, explain: _____

When was the last time you had a physical examination? _____

Have you ever had an exercise stress test: Yes No Don't Know

If yes, were the results: Normal Abnormal

Do you take any medications on a regular basis? Yes No

If yes, please list medications and reasons for taking: _____

Have you been recently hospitalized? Yes No

If yes, explain: _____

Do you smoke? Yes No

Are you pregnant? Yes No

Do you drink alcohol more than three times/week? Yes No

Is your stress level high? Yes No

Are you moderately active on most days of the week? Yes No

Do you have:

High blood pressure? Yes No

High Cholesterol? Yes No

- Diabetes? Yes No
- Have you experienced a
- A heart attack? Yes No
- A stroke? Yes No
- High blood pressure? Yes No
- High cholesterol? Yes No
- Known heart disease? Yes No
- Rheumatic heart disease? Yes No
- A heart murmur? Yes No
- Chest pain with exertion? Yes No
- Irregular heart beat or palpitations? Yes No
- Lightheadedness or do you faint? Yes No
- Unusual shortness of breath? Yes No
- Cramping pains in legs or feet? Yes No
- Emphysema? Yes No
- Other metabolic disorders (thyroid, kidney, etc.)? Yes No
- Epilepsy? Yes No
- Asthma? Yes No
- Back pain: upper, middle, lower? Yes No
- Other joint pain (explain below)? Yes No

Muscle pain or an injury (explain below)? Yes No

To the best of my knowledge, the above information is true.

Print Name: _____

Sign Name: _____

Date: _____