



Medical History

**Please Check:
Yes or No**

Name: _____ Age: _____

Have you ever experienced or do you have any known Cardiovascular Disease: Yes No

Heart arrhythmias	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Rheumatic Fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chest Pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Peripheral Vascular Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>
High blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Anemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Murmur	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Other _____					

Have you ever experienced or do you have any known Pulmonary Disease: Yes No

Emphysema Yes No
 Asthma Yes No
 Other _____

Have you ever experienced or are you currently experiencing:

Convulsions	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Fainting	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heat injury	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Stress Fractures	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Shin Splints	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Concussion	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other _____					

Do you take any over-the-counter medications on a regular basis? Yes No
 Explain: _____

Are you presently taking any prescription medications? Yes No
 If yes, what medication and amount: _____

Were you ever advised to wear a brace during activity? Yes No
 Explain: _____

Please list any **Surgeries, New Medical diagnoses, or Hospitalizations** and dates:

Have you ever sustained an injury to or are you suffering from the following:

Wrist	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Elbow	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Neck	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Shoulder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Knee	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Ankle	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Arthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Back	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Joint Injury	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hip	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other _____					

Was it treated by a physician? Yes No
 Date of last physical exam: _____

Metabolic Disorders

Diabetic Yes No
 Hypoglycemia Yes No
 Other _____

Family History Heart disease: Mother Father Stroke: Mother Father
Other habits Tobacco / Caffeine **Drug allergies:** _____

I understand that it is my responsibility to disclose my medical history, and I have done so to the best of my ability.

Signature _____ **Date** _____