



MEDICAL HISTORY QUESTIONNAIRE

Please check any conditions or diseases you now have or have had in the past

Heart attack, coronary bypass, or other cardiac surgery	Extra, skipped, or rapid heart beats or palpitations
Stroke	Unusual shortness of breath
Phlebitis or emboli	Epilepsy or seizures
High blood pressure	Asthma
Limited range of motion	Migraine/recurrent headaches
Heart murmurs	Chronic recurrent cough
Cold hands or feet	Emotional disorders
Light-headedness or dizziness	Trouble sleeping
Anemia	Swollen/stiff/painful joints
Emphysema	Knee problems
Pneumonia	Back problems
Increased anxiety or depression	Neck problems
Fatigue or lack of energy	Shoulder problems
Bronchitis	Ankle problems
Foot problems	Hip problems
Diabetes	Ulcers
Peripheral vascular disease	Hernia
Rheumatic fever	Arthritis
Low blood pressure	Broken bones
Chest discomfort	Stomach/intestinal problems
Ankle swelling	Bursitis

If you checked any of the above, please explain

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Do you smoke? If yes, how much?	Do you have elevated cholesterol?
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Please list any drug allergies

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Please list any medications you are now taking

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List any surgical procedures, illness, or hospitalizations within the last 2 yrs.

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History of heart disease in family? List age, blood relative, and condition

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Do you have any disease or condition that would limit your exercise capacity or ability? If Yes, Please Explain

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Signature: _____ Date: _____