



Medical History

Name:		Date:		
Please indicate if you (personally) have a history of the following:				
1.	Heart attack		YES	NO
2.	Bypass or cardiac surgery		YES	NO
3.	Chest discomfort with exertion		YES	NO
4.	High blood pressure		YES	NO
5.	Rapid or runaway heartbeat		YES	NO
6.	Skipped heartbeat		YES	NO
7.	Rheumatic fever		YES	NO
8.	Phlebitis or embolism		YES	NO
9.	Shortness of breath w/ or wo/exercise		YES	NO
10.	Fainting or light-headedness		YES	NO
11.	Pulmonary disease or disorder		YES	NO
12.	High blood fat (lipid) level		YES	NO
13.	Stroke		YES	NO
14.	Recent hospitalization for any cause		YES	NO
	Reason:			
15.	Orthopedic conditions (including arthritis)		YES	NO
	Please describe:			

Please list any other diagnosed conditions and when they were diagnosed below: