# MEDICAL QUESTIONNAIRE

**Appointment:**

Time: _____ Resting HR _____ b/min

Date: _____ Resting BP _____ mm/Hg

NAME: _____ PHONE NUMBER: _____

GENDER: male / female BIRTHDAY (year/month/day): _____

E-mail address: _____

Physician: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

## THE FOLLOWING SECTION MUST BE COMPLETED PRIOR TO BOOKING A FITNESS APPOINTMENT

Is your physician aware of your intentions to participate in an exercise program? _____

When was your last doctor's visit? _____

Medications: 1.)_____ For_____ Side Effects: _____

2.)_____ For_____ Side Effects:_____

3.)_____ For_____ Side Effects: _____

Area of injury: _____ Limitations: _____

Area of injury: _____ Limitations: _____

Area of injury: _____ Limitations: _____

Present Therapy: 1.) _____/____/WK With: _____

2.) _____/____/WK With: _____

3.) _____/____/WK With: _____

Present Exercise: 1.)_____/____WK 2.) _____/WK 3.)_____/WK

## Do you have any history of the following? (please circle yes or no)

**Yes/No** advice from physician not to exercise? If yes, explain _____

**Yes/No** family medical history? If yes, explain _____

**Yes/No** heart problem, angina, chest pain or stroke? If yes, explain_____

**Yes/No** high blood pressure? If yes, explain_____

**Yes/No** chronic illness or condition? If yes, explain_____

**Yes/No** difficulty with physical exercise? If yes, explain _____

**Yes/No** recent surgery or injury (last 12 months)? If yes, explain _____

**Yes/No** pregnancy (now or within last 3 months)? _____ Due Date: _____

**Yes/No** are you planning to be pregnant soon? _____

**Yes/No** history of breathing or lung problems? If yes, explain _____

**Yes/No** asthma, do you carry your inhalator with you? _____

**Yes/No** muscle, joint, bone, pain or back disorder? If yes, explain _____

**Yes/No** high blood cholesterol or triglycerides? If yes, explain _____

**Yes/No** thyroid condition (hypo or hyper)? If yes, explain _____

**Yes/No** cigarette smoking habit? If yes, how many / day? _____

**Yes/No** do you drink products which contain caffeine? How many per day? _____

**Yes/No** are you diabetic (insulin dependent or non-dependent)? If yes, what type? _____

**Yes/No** do you have any kidney of liver problems? If yes, explain _____

**Yes/No** have you ever had a hernia? If yes when? _____

**Yes/No** have any allergies? If yes, explain _____

**Yes/No** any other health conditions that may affect your physical fitness? If yes, explain _____

_____

**Yes/No** have you ever seen a dietician or nutritionist? Name: _____

What is your occupation? _____

Job demands? _____

In general, how is your stress level? (1 is the lowest and 5 is the highest) 1 2 3 4 5

About how many hours of sleep do you usually get each night? _____

In general, how would you describe your state of health? _____

☐ very good ☐ good ☐ average ☐ poor ☐ very poor

Anything else Melanie should know about? _____

_____

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Signature: _____ Date: _____