Your Personal Best
Training Studio
Guaranteed Results!

Personal Medical History Survey

Name:_____ **Email:** _____

Local phone number: _____ **Birthdate:**_____ **Age:**_____

Local address:_____

Today's date:___ _____ **Weight:** _____ **Height:** _____ **Marital Status:** _____

In case of an emergency, contact: _____ **Relation:** _____

Address: _____ **Phone number:** _____

1. Have you ever been diagnosed as having: (Check all that apply)

	Never	In past	Presently
A. Heart disease	_____	_____	_____
B. Rheumatic fever	_____	_____	_____
C. High blood pressure	_____	_____	_____
D. Other vascular disorders	_____	_____	_____
E. Diabetes or Low Blood Sugar	_____	_____	_____
F. Kidney disease	_____	_____	_____
G. Asthma	_____	_____	_____
H. Neurological Disorders (Parkinson's, MS, etc.)	_____	_____	_____
I. Chronic bronchitis	_____	_____	_____
J. Arthritis of the spine, hips, knees or ankles	_____	_____	_____
K. Osteoporosis	_____	_____	_____
L. Clinical depression	_____	_____	_____
M. Other:	_____	_____	_____

2. Please indicate any surgery that you have undergone and the approximate date(s):

_____

_____

3. Please indicate recent (past 12 months) illnesses or major injuries that you have had. Also list approximate dates:

_____

_____

4. Please list any and all medications (prescription and non-prescription) that you are presently taking:

	Medication	**Dosage**	**Dosage per day**
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____
6	_____	_____	_____

5. Do you smoke? _____ Packs per day? _____ Smokeless tobacco? _____

6. Describe your present exercise and/or physical activity program (the activity, amount per day, days per week, and the length of time you have been training at this level).

Activity	**Minutes/day**	**Days/week**	**Weeks of participation**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. Do you have any other medical conditions or concerns which should be noted? If so, please describe:

_____

_____

Physician Name: _____ Physician Phone: _____

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8. How did you hear about us? _____ 9. Have you ever had a trainer before? _____

10. Would you like to be added to our fitness newsletter which includes a health recipe every week, fitness and exercise tips, and motivation? YES NO

11. Would you be interested in a free training session and fitness evaluation? YES NO

12. Do you have a friend that might be interested in either? _____

TRAINER'S NOTES:

_____

_____

_____