Medical History Form

Name:_____ **Date:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Cell/Work Phone:**_____

Date of Birth: ____/____/____ **Age:** _____

Height: _____ **Weight:** _____

Physician Information

Name: _____ **Phone:**_____

Are you currently under a doctor's care? **Yes** **No**

If yes, explain:_____

List any medications you are currently taking:_____

_____

Have you ever had an exercise stress test? **Yes** **No**

If yes, were the results normal? **Normal** **Abnormal**

Have you recently been hospitalized? **Yes** **No**

If yes, explain:_____

_____

Do you currently exercise? **Yes** **No**

If yes, what are you currently doing: _____

_____

Emergency Contact Information

Name:_____ **Relationship:**_____

Home Phone:_____ **Cell/Work Phone:**_____

Health History

Please check all of the following conditions that apply to you past or present.

A. Risk Factors

____ Heart attack	Date: _____	Notes: _____
____ Heart Surgery	Date: _____	_____
____ Angioplasty	Date: _____	_____
____ Coronary bypass	Date: _____	_____
____ Stroke	Date: _____	_____
____ Pain or discomfort in chest or surrounding area		_____
____ Irregular heartbeat or palpitations		_____
____ Unusual shortness of breath with or without exertion		_____
____ Asthma		_____
____ Dizziness or passing out		_____
____ Ankle swelling		_____
____ Heart flutters or fast heart rate		_____
____ Known heart murmur		_____
____ Emphysema or lung difficulty		_____
____ Epilepsy or other neurological difficulty		_____
____ Chronic back pain		_____
____ Bone or joint condition		_____
____ Muscle pain or injury		_____
____ Pregnant/give birth in last 6 months		_____
____ High blood pressure	Blood pressure $\geq$ 140/90 or on high blood pressure medication.	
____ Diabetes	Insulin dependent diabetes mellitus and > 30 years of age; or Noninsulin dependent diabetes mellitus and > 35 years of age.	

B. Other Positive Risk Factors

____ Age	Men > 45 years; Women > 55 years
____ Family History	Heart attack or sudden death before 55 years of age in father or other male family member; or before 65 years of age in mother or other female family member.
____ Current Smoker	# of years ____; # of packs per day ____
____ Sedentary Lifestyle	Combination of sedentary job involving sitting for a large part of the day, and no regular exercise or active recreational pursuits.
____ High Cholesterol	Total cholesterol level > 240, or HDL level < 35

C. List any other medical condition which may affect your use of the Renaud Spirit Center

_____

_____

I hereby verify that to the best of my knowledge, the information I have provided on this form is accurate and further more agree to inform the personal trainer of any changes in my health status.

Signature:_____ **Date:**_____/_____/_____

Guardian (if under 18):_____ **Date:**_____/_____/_____

* The Renaud Spirit Center and its personal trainers reserve the right to require a physician's consent form prior to any physical training.