

### **Medical History Form**

- 1. Are you allergic to any medication?**
- 2. Do you take any prescribed medication?**
- 3. Do you have any seizure disorders (epilepsy)?**
- 4. Do you have diabetes?**
- 5. Are you anemic (low blood count)?**
- 6. Do you have high blood pressure (hypertension)?**
- 7. Have you heart, lung, liver, kidney, disease?**
- 8. Do you have asthma?**
- 9. Have you suffered from a severe neck injury?**
- 10. Have you ever been knocked out? Describe**
- 11. Do you wear glasses or contacts?**
- 12. Have you had any broken bones or fracture in the past 2 years? Describe**
- 13. Any back injury? Describe**
- 14. Any back pain? Never, seldom, occasionally, frequently**
- 15. Any knee pain in the past 2 years?**
- 16. Any physical conditions which cause pain?**
- 17. Any surgical procedures? Describe**

**List goals**

**\*Notice\* It is always wise to seek doctors advice before beginning any Health/Fitness program**