

▶ Medical History Questionnaire

Member's Name:			
Please indicate in the space provided if you 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
	List specifics:		
		YES	NO
15	Orthopedic problems (including arthritis)	YES	NO
	List Specifics:		
FOR ANY OF THE CONDITIONS CHECKED ABOVE PLEASE LIST THE DIAGNOSIS AND EXAMINING PHYSICIAN:			