Jean Marie Fitness & Pilates LLC - Medical History Form

Name____Age_______D.O.B________

____

Street Address City State Zip Code

Phone:__________________________________ Email: ______________________________

Emergency Contact Person's Name____

Relationship_________________________Phone______________________________

Goals: What are your 3 top personal fitness and health goals you would like to accomplish?.

1____

2____

3____

What is Your Occupation_____________________________ How long is your work day? _______________Is your job physically or mentally demanding? _________________

List any allergies ____________________________ Are you allergic to latex? Y / N

Please write (Yes) if you're currently receiving any of these professional health care services:

______Medical Doctor (MD) _____Chiropractor ______Physical Therapist _____Psychologist Other_________________________________

MEDICAL HISTORY

Have you experienced or have you been diagnosed as having any of the following conditions?

Yes No Cancer (if yes, what kind____)

Yes No Heart Problems (if yes, what kind_______________________________________)

Yes No High Blood Pressure

Yes No Carpal Tunnel Syndrome

Yes No Circulation Problems

Yes No Dizziness

Yes No Asthma

Yes No Fainting

Yes No Stomach Ulcers

Yes No Thyroid Problems

Yes No Osteoporosis

Yes No Osteopenia

Yes No Shoulder Impingement

Yes No Rheumatoid Arthritis

Yes No Other Arthritic Conditions

Yes No Joint or Back Pain

Yes No Diabetes

Yes No Kidney Disease

Yes No Multiple Sclerosis

Yes No Kidney Disease

Yes No Stenosis (if yes what kind? ____________________________)

If there is anything else you want us to know about your medical history please let us know here:

____

For the next 2 questions, please use the back of this paper if you need more room.

Surgeries: Please list any surgeries you have had which have caused you to be hospitalized.

Date of Surgery Type of Surgery Reason for Surgery

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____

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Injuries: Please list any injuries that may limit or interfere with your movement or that may be getting in the way of your exercise.

Date of Injury Type of Injury

____

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FAMILY HISTORY

Has anyone in your **immediate family** (parents, brothers, sisters) ever been treated for any of the following:

Yes No Diabetes

Yes No Cancer

Yes No Heart Disease

Yes No High Blood Pressure

Yes No Stroke

Yes No Kidney Disease

MEDICATIONS - Which of the following medications have you taken in the last week:

Aspirin Yes No

Tylenol Yes No

Anti-inflammatories (advil, motrin, ibuprofen, etc.) Yes No

List medications you are taking **prescribed by a doctor** (including pills, injections, skin patches):

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