Medical History

Name:			Date:		
Please indicate if you (personally) 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
	Reason:				
15.	Orthopedic conditions (including arthritis)		YES		NO
	Please describe:				

Please list any other diagnosed conditions and when they were diagnosed below:
