PTPOST

Intake and Past Medical History Form

Name: _____
Address: _____**City:** _____
State: _____**Zip:** _____ **Phone: H**_____C_____
Email_____

Do you have any of the following:
Irregular Heartbeats/ Coronary Heart Disease or family history of HD? ___ Yes ___ No
Chest Pain? ___ Yes ___ No
High Blood Pressure? ___ Yes ___ No
Rheumatic Fever? ___ Yes ___ No
High Cholesterol? ___ Yes ___ No
Respiratory Problems or chronic cough? ___ Yes ___ No
Shortness of Breath? ___ Yes ___ No
Diabetes? ___ Yes ___ No
Obesity? ___ Yes ___ No
Arthritis? ___ Yes ___ No
Bone, joint, or muscle injury? __ Yes __ No
Low Back Pain? ___ Yes ___ No
Seizures or Convulsions? ___ Yes ___ No
Severe Headaches? ___ Yes ___ No
Dizziness/loss of consciousness? __ Yes __ No
Family History of Heart Disease? __ Yes __No

Surgery (s)? - What, when, why, how many?
_____
_____
_____
_____
Are you on any medications? (Please list what and why)
_____
_____
_____
_____
____**Do you smoke?** ____ Yes ____ No
Do you have any physical problems that are of concern to you?
_____
_____

_____
_____

What does your physician recommend?

_____
_____
_____

What are your goals for this exercise program?

_____
_____
_____

***CONSULT YOUR PHYSICIAN BEFORE BEGINNING IN ANY EXERCISE PROGRAM**