# Fit Fueled Moms

## Medical History Questionnaire

**PLEASE FILL OUT ALL INFORMATION REQUESTED BELOW**

| Member's Name: | | | Date: | | |
|---|---|---|---|---|---|
| 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: | | | | |
| 15. | Orthopedic problems (including arthritis) | | YES | | NO |
| | List specifics: | | | | |

**FOR ANY OF THE CONDITIONS CHECKED ABOVE, PLEASE LIST THE DIAGNOSIS AND EXAMINING PHYSICIAN:**

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