Medical History Questionnaire

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

ListSpecifics:_____

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