Medical History Questionnaire

Name _____ Date _____

Please indicate if you have a history of the following:	Yes	NO
Heart Attack		
Bypass or Cardiac Surgery		
Chest discomfort with exertion		
High Blood Pressure		
Rapid or Runaway Heartbeat		
Skipped Heartbeat		
Rheumatic Fever		
Phlebitis or embolism		
Shortness of breath with or without exercise		
Fainting or light-headedness		
Pulmonary disease or disorder		
High blood lipid level (fat)		
Stroke		
Recent Hospitalization for any reason		
If yes, explain		
Orthopedic problems (includes arthritis)		
If yes, explain		

If yes to any, explain: