Client Medical Questionnaire

Name: _____ Date: _____

Telephone: _____

Date of Birth:_____ Age: _____ Height: _____ Weight:_____

In Case of Emergency Contact: _____ Relationship:_____

Address: _____ Phone: _____

Physician: _____ Specialty: _____

Address: _____ Phone: _____

Are you currently under a doctor's care: Yes No
If yes, explain: _____

When was the last time you had a physical examination? _____

Have you ever had an exercise stress test: Yes No Don't Know
If yes, were the results: Normal Abnormal

Do you take any medications on a regular basis? Yes No
If yes, please list medications and reasons for taking: _____

Have you been recently hospitalized? Yes No
If yes, explain: _____

Do you smoke? Yes No

Are you pregnant? Yes No

Do you drink alcohol more than three times/week? Yes No

Is your stress level high? Yes No

Are you moderately active on most days of the week? Yes No

Do you have:
High blood pressure? Yes No
High cholesterol? Yes No
Diabetes? Yes No

Have parents or siblings who, prior to age 55 had:
A heart attack? Yes No
A stroke? Yes No
High blood pressure? Yes No

Print Name: _____

Sign Name: _____

Date: _____