Medical History Form

Name_____ Birth Date_____/_____/_____

*Height*_____ *Weight*_____ *BMI*_____ *Goal Weight:*_____

Your overall health is our top priority. Your health concerns including family health history and medications that you are taking will help us to make a proper assessment and overall specialized plan to ensure all aspects of your health are addressed.

Are you currently under the care of a physician? ○ Yes ○ No _____

Have you ever been hospitalized or had a major operation? ○ Yes ○ No_____

Are you taking any prescription medications? ○ Yes ○ No_____

Are you taking any over the counter medications or supplements? ○ Yes ○ No _____

Are you on a special diet? ○ Yes ○ No _____

Do you use nicotine products? ○ Yes ○ No Do you consume alcohol? ○ Yes ○ No _____/per day

Women: Are you Pregnant/Trying to get pregnant? ○ Yes ○ No_____

Taking Oral contraceptives? ○ Yes ○ No_____(what form)__

Do you have any allergies? ○ Yes ○ No_____

Please check if you have/had any of the following medical conditions:

Angina/Chest Pain	○	Cancer	○	Mental Health Disorder	○
Anemia	○	Diabetes	○	Stroke	○
Arthiritis/Gout	○	Heart Disease	○	Stomach Issues/Ulcers	○
Artifical Joint	○	High Blood Pressure	○		
Breathing Problems	○	High Cholesterol	○		
Bleeding Disorder	○	Kidney Problems	○		

Any other serious illness or injury not noted above:_____

Comments/FitnessGoals_____

_____

_____

Signature_____ Date_____