Medical History

Do you currently have, or have you been treated in the past for any of the following conditions?

Arthritis	Osteoporosis	Diabetes
Heart Attack/Disease	Lung Disorders	Respiratory Illness
High Blood Pressure	Stroke	Seizures
Eating Disorders	Lightheaded/Dizziness	Chronic Illness

Orthopaedic conditions: Neck Back Shoulder Elbow Wrist/Hand Hip Knee Ankle/Foot

Please explain: _____

_____

_____

Please list any accidents, injuries, physical ailments, and/or surgeries in the past 5 years:

_____

_____

_____

Have you been released by medical personnel to exercise? YES NO

Please list any medications, supplements, and/or vitamins you are currently taking:

_____

_____

_____

Emergency Contact: Name/Relation _____ Phone_____