



Trainer: \_\_\_\_\_ Location: \_\_\_\_\_  
Date: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm

**Medical History**

Name \_\_\_\_\_  
First Middle Last

Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-Mail \_\_\_\_\_ @ \_\_\_\_\_ . \_\_\_\_\_

Occupation \_\_\_\_\_ Date of Birth \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Age \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

*Please circle "YES" or "NO" and provide additional details where requested on all three sides of this form.*

1.) Are you allergic to any medication (aspirin, penicillin, sulfa, etc.)?  
NO YES (list) \_\_\_\_\_

2.) Do you take any prescribed medication on a permanent or semi-permanent basis (steroids, anti-inflammatories, antibiotics, insulin, etc.)?  
NO YES \_\_\_\_\_

3.) Have you ever been treated for diabetes?  
NO YES (list any medication) \_\_\_\_\_

4.) Have you ever been told by a doctor that you were anemic?  
NO YES When? \_\_\_\_\_ What treatment? \_\_\_\_\_

5.) Do you have or have you ever had high blood pressure?  
NO YES (list any medication) \_\_\_\_\_

6.) Have you ever been told by a doctor that you have asthma?  
NO YES (list any medication) \_\_\_\_\_

7.) Do you have or have you ever had a hernia or "rupture"?  
NO YES (if so, has it been repaired?) \_\_\_\_\_

8.) Have you been "knocked out" or become unconscious in the past three years?  
NO YES (if so, describe and give date(s)) \_\_\_\_\_

9.) Have you had a concussion or other head injury in the past three years?  
NO YES (if so, describe and give date(s)) \_\_\_\_\_

10.) Do you wear glasses or contacts during competition or exercise?  
No YES

11.) Have you had a shoulder injury in the past two years that disabled you for a week or longer (dislocation, separation, etc.)? NO YES

12.) Do you have back pain? NO YES (Circle any that apply)

Seldom Occasionally Frequently With Vigorous Exercise With Heavy Lifting

Where in your body? \_\_\_\_\_ Date(s) \_\_\_\_\_

13.) Do you have any other conditions that we should be aware of (i.e., ulcers, pregnancy, food or insect allergies, tendonitis, etc.)?

NO YES (Specify and give details) \_\_\_\_\_

14.) Do you or have you ever had any knee injuries, pain, or complications with the knees and surrounding areas at all? YES NO

(Please specify if so) \_\_\_\_\_

15.) Please list any other information about your health and past medical history, that may or may not be pertinent information in determining what is safe exercise for you, that has not yet been covered above:

(use block given below)

[Empty rectangular box for additional information]

*The questions on this form have been answered completely and truthfully to the best of my knowledge.*

*Signature of Client (or parent if client is a minor)*

*Date*

\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

*Trainer Signature*

*Date*

\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_