Medical History Form

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Please fill out the information below - all of your answers are confidential, and will be used only to ensure the quality of your fitness program.

If you haven't already, please download the consent form, as well as the policies form (for those registering for the Mom's class, download this version of the policies form).

Name *

First Last

Address *

Street Address

Address Line 2

City

Maryland ▼

State

Zip Code

Email *

Phone Number *

(###) ### ####

Date of Birth *

MM / DD / YYYY

Height and Weight *

Height Weight

Emergency Contact *

Emergency Contact Phone Number *

(###) ### ####

Physician's Name *

Full Name

Physician's Address *

Street Address

Address Line 2

City

Maryland ▼

State

Zip Code

Physician's Phone Number *

(###) ### ####

Date of Your Last Exam

MM YYYY

Are you currently under a doctor's care?

- Yes
- No

If yes, please explain why:

Medical History

Have you ever been diagnosed with heart problems?

- Yes
- No

Do you have excessive trouble breathing during times of exertion?

- Yes
- No

Do you ever have pains in your heart and chest?

- Yes
- No

Has a doctor ever said your blood pressure was too high?

- Yes
- No

Do you smoke? If no, did you ever smoke?

- Yes
- No

Do you have diabetes mellitus?

- Yes
- No

Has your doctor ever told you that you have a bone or joint problem such as arthritis that has been aggravated by exercise or might be made worse with exercise?

- Yes
- No

Have you a history of any condition, e.g. hernia, that may be aggravated by lifting weights?

- Yes
- No

Is there a good physical reason not mentioned here why you should not follow an activity program even if you wanted to?

- Yes
- No

Are you over age 65 and not accustomed to vigorous exercise?

- Yes
- No

Are you pregnant?

- Yes
- No

If you are pregnant, have you received medical clearance for increased physical activity?

- Yes
- No

Are you on any medications?

- Yes
- No

If yes, please list:

List any injuries, past or present, or limiations that may affect your exercise program. (e.g. low back pain, cartilage tear, broken collarbone, etc.)

If you answered yes to any of the questions listed above, you may be required to get your physician's written approval before starting.

Do you like to exercise?

- Yes
- No

Are you currently exercising?

- Yes
- No

If yes, what physical activities are you doing? How often?

Have you ever exercised regularly?

- Yes
- No

If yes, list your reasons for stopping.

Are your family/friends/co-workers willing to exercise with you?

- Yes
- No

Do they encourage you to exercise?

- Yes
- No

Are they willing to rearrange their schedules to accommodate your exercise time?

- Yes
- No

Are there opportunities during your work day when you might use 20-30 minutes for physical activity?

- Yes
- No

Have you ever attended a group exercise class?

- Yes
- No

If yes, what type of class/es? How many per week? For how long?

What are your short term and long term fitness goals?

Have you ever used a personal trainer?

- Yes
- No

If yes, when? Where? How long?

List your reasons for stopping:

Do you have access to exercise equipment in your home?

- Yes
- No

If yes, what type of equipment do you have and do you use the equipment?

If no, would you like to purchase equipment?

- Yes
- No

Please comment on anything that you feel will help me design your exercise program or help me create a more comfortable exercise environment for you.

Submit