MEDICAL HISTORY REVIEW FORM

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: Yes ☐ No ☐

A heart attack? Yes ☐ No ☐

A stroke? Yes ☐ No ☐

High blood pressure? Yes ☐ No ☐

High cholesterol?	Yes ☐	No ☐
Known heart disease?	Yes ☐	No ☐
Rheumatic heart disease?	Yes ☐	No ☐
A heart murmur?	Yes ☐	No ☐
Chest pain with exertion?	Yes ☐	No ☐
Irregular heart beat or palpitations?	Yes ☐	No ☐
Lightheadedness or do you faint?	Yes ☐	No ☐
Unusual shortness of breath?	Yes ☐	No ☐
Cramping pains in legs or feet?	Yes ☐	No ☐
Emphysema?	Yes ☐	No ☐
Other metabolic disorders (thyroid, kidney, etc.)?	Yes ☐	No ☐
Epilepsy?	Yes ☐	No ☐
Asthma?	Yes ☐	No ☐
Back pain: upper, middle, lower?	Yes ☐	No ☐
Other joint pain (explain on back of form)?	Yes ☐	No ☐
Muscle pain or an injury (explain on back of Form)?	Yes ☐	No ☐

To the best of my knowledge, the above information is true.

Print Name: _____

Sign Name: _____

Date: _____

Please return form to Grant Davis at agingstrongtoday2019.com