

# Medical Clearance & Health History Form



Name: \_\_\_\_\_ Email: \_\_\_\_\_

Phone Number:(Home) \_\_\_\_\_ (Work) \_\_\_\_\_

## Medical History

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_/\_\_\_/\_\_\_

Predicted Max Heart Rate: \_\_\_\_\_

Please circle any of the following symptoms that you have experienced:

1. You experience chest discomfort with exertion.
2. You experience unreasonable breathlessness.
3. You experience dizziness, fainting, and blackouts.
4. You take heart medications.
5. You have musculoskeletal problems.
6. You have concerns about the safety of exercise.
7. You take prescription medication(s).

Please circle any of the following conditions you have now or have had in the past:

1. Heart Attack., Stroke, or other heart condition.
2. Heart surgery.
3. Cardiac catheterization.
4. Coronary angioplasty (PTCA).
5. Pacemaker/implantable cardiac defibrillator/rhythm disturbance.
6. Heart valve disease.
7. Heart failure.
8. Heart transplantation.
9. Congenital heart disease.

Do you have a muscle, bone, or joint problem, which you feel would limit your participation in an exercise program? Explain:

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Other medical problems:

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Medications:

Medical Diagnosis: \_\_\_\_\_  
Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Medical Diagnosis: \_\_\_\_\_  
Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Your Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone: \_\_\_\_\_