NAME: ____

EMERGENCY CONTACT INFO: ____

MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems:

Heart disease: Y/N
specify type
Asthma/Lung disease Y/N
High cholesterol Y/N
Thyroid problem Y/N
Kidney disease Y/N
Cancer: (specify): Y/N

High Blood Pressure Y/N
Anxiety Y/N
Diabetes Y/N
Stroke Y/N
Depression Y/N
Other____________________________________
____

SURGICAL HISTORY: Please list all prior operations (with dates):

____
____

ORTHOPEDIC HISTORY: Please list all prior/current injuries/pain:

____
____
____

SOCIAL HISTORY
Tobacco Use
Cigarettes _ Never _ Quit Date
_ Current Smoker: packs/day # of yrs
Other Tobacco: _ Pipe _ Cigar _ Snuff _ Chew
Are you interested in quitting? _ No _ Yes
Alcohol Use
Do you drink alcohol? _ No _ Yes # drinks/week
Is your alcohol use a concern for you or others? _ No _ Yes
Drug Use
Do you use any recreational drugs? _ No _ Yes

OTHER CONCERNS
Caffeine Intake: _ None _ Coffee/tea/soda cups/day
Weight: Are you satisfied with your weight? _ No _ Yes
Diet: How do you rate your diet? _ Good _ Fair _ Poor
Exercise: Do you exercise regularly? _ No _ Yes
What kind of exercise?
How long (minutes) How often?

ARE YOU INTERESTED IN HAVING YOUR OVERALL FITNESS LEVEL ASSESSED? Y/N
(this will include weight/body fat measurements/mobility screening)
If YES how should we contact you to schedule this?_____________________________

"WHEN THE SUN COMES UP IT'S A WHOLE NEW DAY"
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