Medical History 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 ☐