



Medical History

Name _____

Date _____

DOB _____

Height _____

Weight (estimated) _____

Physician _____

Date of Last Physical _____

Occupation _____

Have you ever been diagnosed with any of the following? (Please circle all that apply)

Asthma

Osteoporosis

Seizures

COPD

Cancer

Arthritis (type _____)

High Blood Pressure

Diabetes

Heart Disease

High Cholesterol

Parkinson's

Other _____

Do you currently smoke, or have you in the past?

Please list any medications you are currently taking.

List any orthopedic issues (shoulder or knee surgery, pain in a specific joint, low back pain, etc.) you have.

How often do you currently engage in physical activity?

What type of activity(s) do you take part in on a regular basis?
(walking, jogging, swimming, biking, tennis, softball, etc.)

How often do you expect to work out in the Training Center each week?

How long would you like your workouts to last?

What are the top 3 goals you would like to achieve through exercise?

- 1.
- 2.
- 3.