

HEALTH HISTORY

Please check if you currently have or have had any of the following:

- Diabetes
- Heart condition
- High blood pressure
- Mitral valve prolapse
- Chest pain
- Abnormal EKG/stress test
- Orthopedic surgery
- Problems with bones/joints affecting ability to exercise
- Cancer
- Stroke
- Pregnancy at this time
- Parkinson's
- Seizures/fainting
- Recent, unexplained weight loss
- Neurological condition
- Arthritis
- Lung Disease, shortness of breath or asthma
- Other (explain) _____

Medications: _____

Allergies: _____

I have read and completed this form:

Signature _____ Date _____