PEP4U WELLNESS GYM MEDICAL INFORMATION FORM

Name:	Date:
Emergency Contact Name:	Phone #:
Physician Name:	Phone #:

Do you have any problems, medical diagnoses or difficulties in any of the following areas? Please check the "yes" or "no" box. If yes, please comment or elaborate. If you said yes to any items marked with *, we will need clearance from your doctor.

Has your medical doctor cleared you for exercise? * Heart problems * Irregular heart beat (arrhythmia) * Chest pain * Pacemaker or defibrillator * Circulation problems High or low blood pressure (* if not managed with medication) Breathing problems Hearing probl	System	Do you have any history of?	Yes	No	Comments
* Heart problems * Irregular heart beat (arrhythmia) * Chest pain * Pacemaker or defibrillator * Circulation problems High or low blood pressure (* if not managed with medication) Breathing problems Endocrine * Diabetes Vision problems Hearing problems Hearing problems Swallowing problems Blood Taking blood thinners Stroke Parkinson's Disease Peripheral Neuropathy Other neurological problem Balance problems Falls Memory or thinking problems Joint replacement (when and where) Broken Bones Osteoporosis Arthritis Back Problems Cancer Bowel or bladder incontinence Dizziness	Has your medical doctor cleared you for				
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Bowel or bladder incontinence Dizziness		Back Problems			
Dizziness	Other	Cancer			
Dizziness Other conditions (please list)		Bowel or bladder incontinence			
Other conditions (please list)		Dizziness			
		Other conditions (please list)			
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Please list current medications:

Notes: