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.

System	Do you have any history of…..?	Yes	No	Comments
Has your medical doctor cleared you for exercise?				
Cardio-vascular/ Pulmonary	* 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			
EENT	Vision problems			
	Hearing problems			
	Swallowing problems			
Blood	Taking blood thinners			
Neurological	Stroke			
	Parkinson's Disease			
	Peripheral Neuropathy			
	Other neurological problem			
	Balance problems			
	Falls			
	Memory or thinking problems			
Musculo-skeletal	Joint replacement (when and where)			
	Broken Bones			
	Osteoporosis			
	Arthritis			
	Back Problems			
Other	Cancer			
	Bowel or bladder incontinence			
	Dizziness			
	Other conditions (please list)			

	Please list current medications:

Notes: