FIT 4 ALL MEDICAL FORM

Name: ____

Cell Phone:_______________Home Phone:___________________ Today's Date:_______

Email: ____

Address:____

DOB:_________________________________ Age:_______________________________________

Primary Care Physician Name and Number:____

Date of Last Physical:____________________ Notable Findings:____________________________

Height:___________________ Weight:____

Ideal Weight:____________________Goals:____

Daily Stress Level (1-low, 10-high)_______________Occupation:_________________________

Hours of Sleep Per Night:______________________Level of Energy (1-low, 10-high)___________

List any medications you are currently taking or have taken in the last 6 months:

List any supplements you are taking or have taken in the last 6 months:

List any operations you have had and the date of surgery:

Do you exercise? Y/N If yes, how many times per week and what do you do?

Are there any factors that may affect your safe participation in a fitness program?

Please circle if you have or have had any of the current conditions:

Anemia	Arthritis	Asthma	Back pain/injury
Bursitis	Cancer	Diabetes	Dizziness
Epilepsy	Headaches	Heart Problems	Hernia
Hypoglycemia	Joint Problems	Kidney Problems	Liver Disease
Lung Disease	Shortness of Breath	Ulcer	Weight Problems
Chest Pains	High Blood Pressure	Thyroid Problems	High Cholesterol
Osteoporosis	Neurological Disorder	Other	

Please circle if there is a family history of:

Heart Disease   Hypertension   High Cholesterol   Heart Attack

Diabetes   Stroke   Obesity

Do you smoke: Y/N   Have you ever smoked: Y/N

Are you pregnant or trying to become pregnant: Y/N

Explain your current eating habits. Are you on a special diet?

For staff only

RestHR_______MaxHR_____VO2max_____

M)108.844 F)100.5– [lbs./2.2(0.1636)]–[time(1.438(1mile))]–[HR@end(0.1928)]

Weight______Height_____BodyFat_____Measurements:Waist____Thigh____Chest____Arms_