



CHI RHO SPORTS & FITNESS

Medical History Form

1. Are you allergic to any medication?
2. Do you take any prescribed medication?
3. Do you have any seizure disorders (epilepsy)?
4. Do you have diabetes?
5. Are you anemic (low blood count)?
6. Do you have high blood pressure (hypertension)?
7. Have you heart, lung, liver, kidney, disease?
8. Do you have asthma?
9. Have you suffered from a severe neck injury?
10. Have you ever been knocked out? Describe
11. Do you wear glasses or contacts?
12. Have you had any broken bones or fracture in the past 2 years? Describe
13. Any back injury? Describe
14. Any back pain? Never, seldom, occasionally, frequently
15. Any knee pain in the past 2 years?
16. Any physical conditions which cause pain?
17. Any surgical procedures? Describe

List goals

***Notice* It is always wise to seek doctors advice before beginning any Health/Fitness program**