BINGHAMTON UNIVERSITY
STATE UNIVERSITY OF NEW YORK

Department of Health and Wellness Studies

MEDICAL HISTORY FORM

Name: _____ **Date:** _____
Last *First* *MI* *(MM/DD/YYYY*

B Number: _____ **Sex:** M _____ F _____ **DOB:** _____
MM/DD/YYYY

Physician's Name: _____ **Physician's Phone:** ( ) -

Emergency Contact: _____

Relation: _____ **Phone (H):** ( ) - **Phone (W)** ( ) -

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What regular physical activity do you presently do? _____

_____

Does your physician know that you are participating in an exercise program? Yes _____ No _____

Do you have any allergies? Yes _____ No _____ **If so, what?** _____

Please list all medications you are presently taking: _____

Are you or have you been pregnant within the past three (3) months? Yes _____ No _____

Please answer the following questions:	**YES**	**NO**
1. Do you have any chronic or recent illness?		
2. Do you have a history of heart problems?		
3. In the past 3 years, have you had episodes of chest pain at rest or during exertion?		
4. In the past 3 years,have you experienced a shortness of breath?		
5. In the past 3 years, have you experienced uneven, irregular or skipped heartbeats?		
6. Do you have a history of high blood pressure?		
7. In the past 3 years, have you experienced episodes of dizziness, seizures or convulsions?		
8. Do you have a history of fainting spells?		
9. Is heart disease present in your family?		
10. Have you ever been told that a member of your family died suddenly or had a heart attack at an early age?		
11. Do you have a history of high cholesterol?		
12. Do you have a history of lung problems?		

cont'd….	YES	NO
13. Do you smoke cigarettes? If so, how many a day?		
14. Are you diabetic?		
15. Do you have asthma?		
16. Are you more than 30% overweight?		
17. Do you have a history of anorexia or bulimia?		
18. Have you had surgery in the past 3 years?		
19. Do you have any muscle, joint, or back disorders that could potentially be aggravated by physical activity?		
20. Have you ever been diagnosed with mononucleosis?		
21. Do you have difficulty with physical activity?		
22. Have you been advised by a physician not to participate in physical activity or exercise?		
23. Do you know of or believe there is ANY reason you should not participate in this exercise program?		

If you answered *YES* to questions 1-23, please provide a brief detailed explanation in the space below:

Please carefully read the following:

Although exercise testing and exercise participation are relatively safe for most otherwise healthy individuals under the age of 45, the reaction of the cardiovascular system to increased levels of physical activity cannot always be predicted. Consequently, there is a small, but real risk of certain changes occurring during exercise testing and participation. It is, therefore, of great importance that you have answered ALL questions HONESTLY. Understand that exercise may be contraindicated for some of the conditions listed above; others may simply require special consideration.

If any of the medical conditions referenced on this form apply to you, you should consult your physician before beginning an exercise program. You should promptly report to your instructor any exercise-related abnormalities that you may experience during the course of the semester.

I HAVE READ THE ABOVE AND UNDERSTAND THAT HEALTH PROBLEMS MAY AFFECT MY ABILITY TO PARTICIPATE IN THIS CLASS.

Signature: _____ **Date:** _____