

Health Form
Please Print & Complete All Sections

Last Name: _____

First Name: _____

Address: _____
(Street/P.O. Box)

Phone: _____
(Day)

(City, State, Zip Code)

(Evening)

E-mail _____

Medical Insurance Information: (Major Medical Coverage is required)

Insurance Company Name: _____

Policy Number: _____

Please indicate below if you have one or more of the following conditions:

High Blood Pressure	Yes	No	Allergies	Yes	No
High Cholesterol Level	Yes	No	Arthritis	Yes	No
Diabetes	Yes	No	Heart Murmurs	Yes	No
Epilepsy	Yes	No	Lung Disease	Yes	No
Pregnant	Yes	No	Shortness of Breath	Yes	No
Smoke Tobacco	Yes	No	Hernia	Yes	No
Asthma	Yes	No	Back Problems	Yes	No
Recent surgery	Yes	No	Joint Problems	Yes	No

Are you returning to exercise after an extended period of time: Yes No

For all "Yes" answers above, please describe/explain the condition(s) below:

Please list any other health-related conditions you may have:

List all prescription and/or over-the-counter drugs you are presently taking:

List any medications you are allergic to:

Emergency Contact Person _____

Day Phone: _____

Evening Phone: _____