



HEALTH & FITNESS HISTORY

Please check if you have any of the following:

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Muscle/Joint Injury | <input type="checkbox"/> Fractures |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Back Injury | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer | <input type="checkbox"/> Valve Replacement |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Diabetes | <input type="checkbox"/> History of falls |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Lung Disease/COPD | <input type="checkbox"/> Angina/Chest Pain |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Other: _____ | |

Are you a smoker YES NO

Do you use insulin YES NO

COMMENTS:

YEARLY REVIEW: I attest that all health history information above remains an accurate representation.

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____