Health Form

Please Print & Complete All Sections

Last Name: _____ **First Name:** _____

Address: _____ **Phone:** _____
(Street/P.O. Box) **(Day)**

_____ _____
(City, state, zip code) **(Evening)**

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 Pains**	**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 prescriptions and/or over-the-counter drugs you are presently taking:

Please list any medications you are allergic to :

Emergency Contact Person: _____
Day Phone: _____**Evening Phone:** _____

updated 1/1/03