MEDICAL HISTORY

NAME:_____ **DATE:** _____

ADDRESS:_____ **SEX: M / F**

Postcode: _____ **D.O.B:** _____

TELEPHONE: Mobile:_____ **Home:**_____

EMAIL: _____

MEDICAL HISTORY

In the past have you ever had (tick No or Yes. Also tick Current if you still have the illness or injury).

MEDICAL CONDITION	NO	YES	CURRENT	MEDICAL CONDITION	NO	YES	CURRENT
Cardiovascular Disease	❑	❑	❑	Shoulder, Elbow, Wrist Injury	❑	❑	❑
High Blood Pressure/Cholesterol	❑	❑	❑	Knee or Ankle Injury	❑	❑	❑
Blood Diseases	❑	❑	❑	Back or Neck Injury	❑	❑	❑
Contagious Diseases	❑	❑	❑	Hip Injury	❑	❑	❑
History of Cancer	❑	❑	❑	Skin Conditions	❑	❑	❑
Asthma	❑	❑	❑	Are you Pregnant?	❑	❑	n/a
Epilepsy	❑	❑	n/a	Varicose Veins	❑	❑	❑
Stroke	❑	❑	❑	Broken Skin	❑	❑	❑

Give details of injuries to your back, neck, shoulders, elbows, wrists, hips, knees, or ankles in your medical history

List any prescribed medications being taken and what condition/s they are taken for

List any relevant surgical procedures that you have had (write the year in brackets):

ALLERGIES: Do you have any allergies, e.g. grass, latex NO ❑ **YES** ❑ **If yes, give details:**

SYMPTOMS DURING OR AFTER EXERCISE

As a result of exercise, have you ever experienced any of the following:

Symptom during exercise	NO	YES	Symptom during exercise	NO	YES
Pain or discomfort in the chest, back, arm, or jaw	❑	❑	Palpitations (heart rhythm disturbance)	❑	❑
Severe shortness of breath or problems with breathing during mild exertion	❑	❑	Pain in the legs during mild exertion	❑	❑
Dizziness, nausea or fainting	❑	❑	Severe heat exhaustion	❑	❑

CARDIOVASCULAR RISK FACTORS

Do you have (tick NO, YES or DON'T KNOW)

Cardiovascular Risk Factors	NO	YES	DON'T KNOW	
High Blood Pressure	❑	❑	❑	
High Blood Cholesterol/Triglycerides	❑	❑	❑	
Diabetes	❑	❑	❑	
Current Smoker	❑	❑	Average/day =	
Ex-smoker	❑	❑	Average/day =	
Do you drink alcohol regularly?	❑	❑	Average/day =	drinks

Client Declaration

I declare that the above information is to my knowledge true and correct, and that I have not omitted any information that is requested on this form. I declare that I will provide the therapist with any additional health and injury information as it arises prior to any treatment.

SIGNED: _____ **DATE:** / /

Personal Trainer Use Only

Does this client need to be referred to a medical practitioner for a medical clearance before commencing the boot camp?

YES or **NO**

List the symptoms/conditions requiring a clearance:

_____