

## ***Fitness Evaluation – Part 1***

### **Medical History**

Test Evaluator:	Test Date:
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Client:	Sex: M F	Birthdate:	Age:
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Address:	Phone:	Phone: (W)
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Height:	Weight:	Desired Weight:
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**Check all that apply:**

	Arthritis		Asthma, emphysema, bronchitis
	Back pain		High blood pressure
	Knee or other joint pain		Coronary Disease
	Shin Splints		Heart Disease
	Foot Pain		Any known heart problems
	Muscle Pain		Stroke
	Other Pain		Epilepsy
	Light-headedness or Fainting		Are you diabetic
	Chest pain at rest or exertion		Hypoglycemia
	Shortness of Breath		Are you pregnant
	Hernia		Family history of Coronary disease before 55
	Do you smoke or use tobacco		History of Atherosclerotic disease before 55
	Elevated Triglyceride Levels		Surgeries, Hospitalization

	Elevated Cholesterol, LEVEL:		Doctor's Physical, DATE:
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**List current medications:**

**List current supplements:**

**Additional Notes:**

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