HEALTH QUESTIONNAIRE

- **Please circle yes or no and briefly explain any "yes" answers in the space provided for each question. If you have a medication list, a copy can be scanned into your health record.**

1. Are you presently restricted or have medical limitations by your physician or employer?	Yes	No
2. Have you recently had any surgery which could limit your activity?	Yes	No
3. Do you have high blood pressure (greater than 140/90)?	Yes	No
4. Have you recently experienced chest discomfort and or shortness of breath?	Yes	No
5. Do you feel faint or have spells of severe dizziness?	Yes	No
6. Have you ever had a blood clot?	Yes	No
7. Do you currently have an infection?	Yes	No
8. Do you currently have a metabolic disease (diabetes, gout, etc.)?	Yes	No
9. Are you pregnant?	Yes	No
10. Are you currently taking any prescription or non-prescription medication?	Yes	No
11. Do you have any history of abdominal or groin problems, including hernias?	Yes	No
12. Have you ever had any major surgery, general or orthopedic?	Yes	No
13. Do you have any history of strokes, cancer, or heart disease?	Yes	No
14. Are there any other conditions or medical issues that we need to be aware of?	Yes	No
15. Please give your estimated weight and height in the boxes shown to the right.	Wt.	Ht.

I understand all of the above questions and have answered them to the best of my knowledge.

_____ _____

SIGNATURE (PATIENT, PARENT, RESPONSIBLE PARTY) **DATE**