PARTICIPANT'S MEDICAL HISTORY & PHYSICAL INFORMATION

Markee Personal Training

Please legibly print the information requested below.
Circle "Yes / No" answers as appropriate.

Participant's Full Name: ____

Participant's Residence Address: ____

City: ______________________________ **State:** __________ **Zip Code:** ______

Phone Numbers: *Day:* **(___)** ___________ *Evening:* **(___)** ___________ *Cell:* **(___)** _________

Participant's Primary Email: ____

Male / Female **Age:** ________ **Height:** ________ **Weight:** ________ **D.O.B.:** __________

Check All That Apply:

- ☐ Recent illness, hospitalization or surgery
  Please describe: ___________________
  ____
- ☐ Heart attack, coronary bypass, cardiac surgery, stroke
- ☐ Abnormal resting or stress ECG
- ☐ Uneven, irregular or skipped heart beat *(incl. a racing or fluttering heart)*
- ☐ Abnormal blood lipids
- ☐ Family history of coronary or other atherosclerotic disease prior to age 55 in males or age 65 in females
- ☐ Diabetes Mellitus
- ☐ High Blood Pressure
- ☐ Phlebitis Emboli
- ☐ Pulmonary disease *(incl. asthma, emphysema and bronchitis)*
- ☐ Rheumatic Fever
- ☐ Light-headedness or fainting
- ☐ Chest pain at rest or exertion
- ☐ Unusual shortness of breath
- ☐ Orthopedic problems *(incl. arthritis or any other bone, joint or muscle problems)*
- ☐ Auto-Accident or other Collision
- ☐ Emotional disorders
- ☐ Medication / Drug Allergies
- ☐ Smoking
- ☐ Physical inactivity

Describe your general health: ____

____

Is there any reason you can't exercise or do you have any physical handicap or medical requirement which might affect your safety or well-being during exercise? *Please describe any current or ongoing medical or physical issues such as heart disease, diabetes, asthma, epilepsy, pregnancy or other conditions:*

Yes / No **If yes, describe:** ____

Your Primary Physician's Name, Phone Number and Facility: ______________________________

Your Emergency Contact's Name: ______________________________ **Relation:** _______________

Phone Numbers: *Day:* **(___)** ________ *Evening:* **(___)** ________ *Cell:* **(___)** ________

Please also complete, date and sign the reverse

When did you last see a physician? ______________ For what reason? _________________________________

Are you currently taking any medications? Yes / No If yes, describe: ______________________________

Have you had surgery? Yes / No If yes, please describe all surgeries and when they were done: ___________

____

Do you have trouble sleeping? Yes / No Do you drink several cups of coffee during the day? Yes / No

Do you eat foods high in fiber each day (e.g., whole grain bread, cereal, or fresh fruit or vegetables)? Yes / No

How many meals do you eat each day? _____________________ Do you eat breakfast regularly? Yes / No

What is your current daily caloric intake? _______ Do you often crave sugar? Yes / No

List all Dietary Restrictions: ____

Do you have any allergies to specific foods, medications or insect bites? Yes / No If yes, describe: ________

____

Are you currently taking nutritional supplements *(e.g., ephedrine, protein, growth hormone, diet pills, energy drinks, etc.)?* Yes / No If yes, describe: ____

Have you ever participated in a diet and/or nutrition program? Yes / No If yes, describe: ________________

Did you achieve your diet and/or nutritional goal? Yes / No Was it permanent? Yes / No

List all exercise programs in which you have previously participated: ____________________________________

Do you currently exercise? Yes / No If yes, describe the type of exercise and days per week and minutes per day:

____

List all other sports/physical activities in which you currently participate: _________________________________

What are your desired exercise goals *(e.g., weight, strength, flexibility, etc.)*? ______________________________

____

How do you expect to achieve these goals? ____

Rate how serious you are about achieving your exercise goals: *Not serious*– **1 2 3 4 5 6 7 8 9 10** –*Most serious*

By my signature below, I affirm that, to the best of my knowledge, I have honestly, correctly and completely described my health, physical and medical condition and medications. I further agree to keep Pam Markee or my assigned trainer updated [916-704-4330; Pam@MarkeePersonalTraining.com] in the event that my health, physical, or medical condition or medication(s) change.

Date: _________________ **Participant's Signature:** ____________________________________