MEDICAL HISTORY FORM

Name:_____ Tel:_____ DOB:_____

Male:_____ Female:_____

Your physician's name:_____
Tel: ( ) Fax: ( )

Please answer YES or NO to the following questions:

_____Heart attack, coronary bypass, stroke

_____Abnormal resting or stress ECG

_____High blood pressure

_____Epilepsy

_____High blood pressure (under a physician's care)

_____Chest pain during exercise or at rest

_____Uneven, irregular, or racing heart beats

_____Pulmonary disease (asthma, emphysema)

_____Family history of heart disease under 55 (parents, siblings)

_____Abnormal blood lipids

_____Diabetes

_____Lightheaded or fainting spells

_____Unusual shortness of breath

_____Bone, joint or muscular problems

_____Physical inactivity (sedentary lifestyle)

_____Other _____

Has your physician or medical professional advised you not to participate in an exercise program or do you know of any reason you should not participate in an exercise program? If answer is YES, we require medical clearance from your Physician.

I understand and have answered all questions correctly to the best of my knowledge. I also understand there is a chance of injury associated with any exercise program and hereby release Collier County Government and the Parks and Recreation Department from any liability now or in the future.

All information disclosed on this form is applicable to the 2024 calendar year. If any information disclosed on this form should change before the end of 2024, I will promptly provide an updated form.

I hereby affirm that I have read and fully understand the above.

_____ _____

Signature Date