MEDICAL HISTORY FORM

Name:_____ **Tel**:_____ **DOB**:_____

Male _____ Female _____

Your Physician's name: _____
Tel: ( ) - **Fax**: ( ) -

Please answer YES or NO to the following Question :

_____ Heart attack, coronary bypass, stroke Complete rehab? _____ When?_____
_____ Abnormal resting or stress ECG
_____ High blood pressure
_____ Epilepsy
_____ High blood pressure (under 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
_____ Light headed or fainting spells
_____ Unusual shortness of breaths
_____ Bone, joint or muscular problems
_____ Physical inactivity (sedentary lifestyle)
_____ Other _____

_____ **Has your physician or any 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 you 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 Recreational Department from any liability now or in the future.

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

_____ _____
Signature **Date**