# Sample Health History Form

Name_____ Date_____

Age_____Sex M__ F__

Physician's Name_____

Physician's Phone (_____)_____

Emergency Contact:

Name_____Phone (_____)_____

Are you taking any medications or drugs? If so, please list medication, dose and reason.

_____

_____

Does your physician know you are participating in this exercise program?

_____

_____

Describe any physical activity you do somewhat regularly.

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