

# MEDICAL QUESTIONNAIRE

All responses are confidential. We use this information only to better assist you during the program, not to screen participants (unless participation would be medically inadvisable). Attach additional sheets if necessary.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. Please briefly describe your current overall health.
2. Describe any history (include dates) of back/spine/neck problems, and indicate whether they still give you problems. Please be specific.
3. Describe any history (include dates) of joint problems (knee, hip, shoulder, etc.), including joint repair/ replacement surgeries. Please be specific.
4. Blood pressure (circle one): High / Low / Normal . When was it last checked? \_\_\_\_\_  
Have you ever taken blood pressure medication? Yes / No. If so, how recently? \_\_\_\_\_
5. Describe any history (even if you are just “at risk”) of cardiovascular problems.
6. Circle any of the following difficulties you have had and explain relevant specifics: Diabetes / Osteoporosis-Osteopenia / Chronic headaches / Ulcers / Stroke / Seizures / Allergies / Asthma / Cancer / Frequent dizziness / Other \_\_\_\_\_
7. Women: Are you pregnant? Yes / No. If so, when is your baby due? \_\_\_\_\_
8. Do you have any other limitations, dietary restrictions, or health concerns? If so, please explain.
9. Are you currently seeing a physician or therapist for any physical or psychological conditions? Yes / No. If yes, what conditions?
10. Are you now taking medication for any physical or psychological conditions? Yes / No.  
If yes, what medications you taken for which conditions and with what frequency? (If you have asthma medications and/or nitroglycerine, please keep them with you at all times.)
11. If you have any learning disabilities, or other special physical or psychological circumstances, please explain below so we can better serve you during this program.

I hereby certify that the above information is correct to the best of my knowledge, and I will continue taking all medications as prescribed by my physician(s) while participating in the teaching training program.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PARTICIPANT'S NAME

\_\_\_\_\_  
PARTICIPANT'S SIGNATURE