



Is there a family history of heart disease, hypertension, stroke, diabetes, heart failure, lung disease, or epilepsy? \_\_\_\_\_ Yes \_\_\_\_\_ No

If YES, please provide information regarding who the relative is, the medical problem, and the age of onset or death :

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\_\_\_\_\_ Yes \_\_\_\_\_ No Do you currently smoke cigarettes?

If YES, how many cigarettes per day? \_\_\_\_\_

If you smoked in the past, when did you quit? \_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No Are you currently taking medication prescribed by a physician?

If YES, indicate name of medication, dosage, and reason why you are taking it :

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Please list below any additional exercise information which you think is important for us to know.

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