Maurice Rivers

Medical History Questionnaire

PLEASE FILL OUT ALL INFORMATION REQUESTED BELOW

Member's Name:			Date:	
Please indicate in the space provided if you have a history of the following:				
1.	Heart attack		YES	NO
2.	Bypass or cardiac surgery		YES	NO
3.	Chest discomfort with exertion		YES	NO
4.	High blood pressure		YES	NO
5.	Rapid or runaway heartbeat		YES	NO
6.	Skipped heartbeat		YES	NO
7.	Rheumatic fever		YES	NO
8.	Phlebitis or embolism		YES	NO
9.	Shortness of breath w/ or wo/exercise		YES	NO
10.	Fainting or light-headedness		YES	NO
11.	Pulmonary disease or disorder		YES	NO
12.	High blood fat (lipid) level		YES	NO
13.	Stroke		YES	NO
14.	Recent hospitalization for any cause		YES	NO
	List specifics:			
15.	Orthopedic problems (including arthritis)		YES	NO
	List specifics:			

FOR ANY OF THE CONDITIONS CHECKED ABOVE, PLEASE LIST THE DIAGNOSIS AND EXAMINING PHYSICIAN:

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