ADDITIONAL QUESTIONS

	YES	NO
8. Have you ever had a history of respiratory or lung problems?	☐	☐
9. Are you currently on any medications that directly affect the heart, lungs, or circulatory system (i.e. blood pressure medications)? If **YES**, please list: ____ ____		
10. Do you have high cholesterol?	**Don't know**	☐
11. Do you know what your cholesterol scores are? Total Cholesterol_________ HDL____________		☐
12. Do you have a chronic illness or condition? If **YES**, please list: ____	☐	☐
13. Do you have a hernia, or any condition that may be aggravated by lifting weights? If **YES**, please list: ____ ____	☐	☐
14. Do you smoke?...................................If **YES,** how many packs a day?_____	☐	☐
15. Have you had surgery within the past 12 months?	☐	☐
16. Do you have a thyroid problem?	☐	☐
17. Are you currently pregnant or have been within the past 3 months?	☐	☐

18. Please list any information that you feel we should know before setting you up on an exercise program:

____

____

19. Person to be contacted in case of emergency:____

20. Physician's Name:____Phone:________________________________

I understand this Medical History Questionnaire serves as a preliminary screening resource to assist our professionals in the determination of patient risk to exercise. If the information above indicates an increased risk for exercise, I authorize Edger Therapy, P.A., to contact my physician for approval and recommendations for my exercise program. If I am at risk and have not received medical clearance, I understand I cannot engage in any exercise or assessments. I shall agree not to hold the testing professional liable for any injuries or damages arising from my failure to disclose pertinent medical information.

____ ______________________________

Signature **Date**