G R A Y M O N T A N A

F I T N E S S & C O N D I T I O N I N G

Medical History/Risk Stratification

Name ____ **DOB** _______________

Contact Phone Number __________________________

Have you EVER been diagnosed with ANY of the following?

Heart Condition	Yes □	No □	Type: ______________________________			
Cancer	Yes □	No □		Arthritis	Yes □	No □
Hypertension	Yes □	No □		Pulmonary Disease / Asthma	Yes □	No □
Diabetes	Yes □	No □		Stomach ulcer	Yes □	No □
Osteoporosis	Yes □	No □		Alcoholism / Drug Addiction	Yes □	No □
Kidney Disease	Yes □	No □		Depression	Yes □	No □
Hepatitis	Yes □	No □		Thyroid Disease	Yes □	No □
Neurological Disease	Yes □	No □		Tuberculosis	Yes □	No □

Have you experienced ANY of the following in the past year?

Fallen this year	Yes □	No □	Joint / Muscle swelling	Yes □	No □
Weight loss / gain	Yes □	No □	Bruising easily	Yes □	No □
Difficulty sleeping	Yes □	No □	Arm / Leg swelling	Yes □	No □
Fatigue	Yes □	No □	Excessive bleeding	Yes □	No □
Weakness	Yes □	No □	Difficulty breathing	Yes □	No □
Fever/Chills/Sweating	Yes □	No □	Regular cough	Yes □	No □
Tremors	Yes □	No □	Heart racing/palpitations	Yes □	No □
Seizures	Yes □	No □	Difficulty swallowing	Yes □	No □
Double vision	Yes □	No □	Heartburn / indigestion	Yes □	No □
Loss of vision	Yes □	No □	Constipation	Yes □	No □

Eye redness	Yes □	No □	Blood in stools	Yes □	No □
Nausea / vomiting	Yes □	No □	Difficulty urinating	Yes □	No □
Hearing problems	Yes □	No □	Difficulty holding urine	Yes □	No □
Skin rash	Yes □	No □	Blood in your urine	Yes □	No □
Excessive Stress	Yes □	No □	Use a Walker or Cane	Yes □	No □
Numbness / tingling	Yes □	No □			

Do you have any known allergies? ____

Please list **ALL** prescription medications/dosages and dietary supplements [or provide your own LIST]