STRONG SENIOR Fitness Program
Cove Senior Citizens Association
Participant's Medical History and Current Health Survey

Name:________________________________ Age:__________ Date:____________

Please read the following list carefully and circle YES or NO as it applies to your medical history and current health. Please include any additional information and conditions for which you are receiving medical care in the open space.

| **MEDICAL HISTORY** | | |
|---|---|---|
| Aneurysm | YES | NO |
| Arthritis: Rheumatoid or Osteoarthritis | YES | NO |
| Asthma | YES | NO |
| Back Pain | YES | NO |
| High Blood Pressure (Last reading: _____/_____) | YES | NO |
| Low Blood Pressure (Last reading: _____/_____) | YES | NO |
| Bone Fractures | YES | NO |
| Cancer: Type and Treatment: | YES | NO |
| High Cholesterol (last reading _____/_____) | YES | NO |
| Diabetes: Type I or Type II | YES | NO |
| Emphysema | YES | NO |
| Heart Disease | YES | NO |
| Family History of Heart Disease: Mother, Father, Siblings | YES | NO |
| Hernia | YES | NO |
| Joint or Ligament Injuries | YES | NO |
| Muscle Injuries | YES | NO |
| Neck Pain or Injury | YES | NO |
| Osteoporosis | YES | NO |
| Surgery | YES | NO |
| Terminal Illness | YES | NO |
| Vertigo or Lightheadedness | YES | NO |
| Other: | | |
| Medications currently taking: | | |