



Health History Form

Name _____ Date _____
 Age _____ Sex F M

Physician's Name _____
 Physician's Phone (____) _____

Person to contact in case of an Emergency:
 Name _____ Phone _____

Are you taking any medications or drugs? If so, please list medication, dose, and reason.

Does your physician have any restrictions for you?

Describe any physical activity you do somewhat regularly.

<i>Do you now, or have you had in the past:</i>	Yes	No
1. History of heart problems, chest pain, or stroke	<input type="checkbox"/>	<input type="checkbox"/>
2. Increased blood pressure/hypertension	<input type="checkbox"/>	<input type="checkbox"/>
3. Any chronic illness or condition	<input type="checkbox"/>	<input type="checkbox"/>
4. Epilepsy or seizures current or past	<input type="checkbox"/>	<input type="checkbox"/>
5. Advice from physician not to exercise	<input type="checkbox"/>	<input type="checkbox"/>
6. Recent surgery (last 12 months)	<input type="checkbox"/>	<input type="checkbox"/>
7. Pregnancy (now or within last 3 months)	<input type="checkbox"/>	<input type="checkbox"/>
8. History of breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/>
9. Muscle, joint, or back disorder, or any previous injury still affecting you	<input type="checkbox"/>	<input type="checkbox"/>
10. Diabetes Type I or II	<input type="checkbox"/>	<input type="checkbox"/>
11. Cigarette smoking habit (packs/day _____)	<input type="checkbox"/>	<input type="checkbox"/>
12. Obesity (more than 20% over ideal body weight)	<input type="checkbox"/>	<input type="checkbox"/>
13. Increased blood cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
14. History of heart problems in immediate family	<input type="checkbox"/>	<input type="checkbox"/>
15. High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
16. Stress or Depression	<input type="checkbox"/>	<input type="checkbox"/>
17. Thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>
18. Liver or Kidney disease/disorder	<input type="checkbox"/>	<input type="checkbox"/>

Release

I know of no physical or mental condition which I, or my primary doctor, feel could be aggravated by my using of light/sound equipment or participating in any program. I agree to advise HS of Tulsa in writing if any of the above information changes or if my primary doctor advises me to stop, reduce or modify. I will advise HS of Tulsa immediately if I notice any changes negatively in my body. I will adhere to the advice of HS of Tulsa and my Primary physician regarding this program.

Name: _____ Date: _____

Signature: _____ Doctor: _____