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:

Please note: possession of this form does not indicate certification status with the ISSA. To confirm active certification status, please call 1.800.892.4772 (1.805.745.8111 international). Information gathered from this form is not shared with ISSA. ISSA is not responsible or liable for the use or incorporation of the information contained in or collected from this form. Always consult your doctor concerning your health, diet, and physical activity.