SIZE WIZE
MEDICAL ASSESMENT FORM

NAME D.O.B. HEIGHT WEIGHT

PRIMARY PHYSICIAN OTHER PHYSICIANS (INCLUDE SPECIALTY)

WHAT ARE YOUR GOALS FOR THIS PROGRAM:

MEDICAL HISTORY: (CIRCLE ALL THAT APPLY):

DIABETES HIGH BLOOD PRESSURE THYROID PROBLEMS ARTHRITIS (LOCATION) ____________________________

ARTHRITIS (LOCATION)____________________ HIGH CHOLESTEROL CONGESTIVE HEART FAILURE

HEART ATTACK SLEEP APNEA SEIZURES OTHER ______________ OTHER ___________________

MEDICATIONS:

1. ______________________________ 6. ______________________________
2. ______________________________ 7. ______________________________
3. ______________________________ 8. ______________________________
4. ______________________________ 9. ______________________________
5. ______________________________ 10. ______________________________

SURGERIES:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

DO YOU HAVE ANY HISTORY OF MAJOR INJURIES?

HAVE YOU EVER HAD SEVERE CHEST PAIN OR SHORTNESS OF BREATH THAT CAUSED YOU TO STOP EXERCISING?

DO YOU HAVE ANY DIETARY RESTRICTIONS?