**Medical Form**

**Health And Medical Form**

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Height (cm) \_\_\_\_\_\_\_\_\_\_\_\_\_\_** *(If Known)* **Weight (kg) \_\_\_\_\_\_\_\_\_\_\_\_\_\_** *(If Known)*

**In Case of Emergency Contact** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Doctor’s Surgery** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**From your knowledge do you have/had/do any of the following?**

*(Please tick or highlight that which applies)*



Cancer / Leukaemia Thyroid

 

High / Low Blood Pressure Diabetes



Epilepsy Migraines / Headaches



Asthma Bone / Joint Problems



Pregnant Planning a Pregnancy 



Smoke Arthritis / Rheumatism 



Heart Conditions Sport / Muscle Injury 



Back Weakness Recently Had a Baby

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Are you currently taking medication? Yes No**

*(Please tick or highlight that which applies)*

If yes please state \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In the last year have you had any major illness or major surgery?**

*(Please tick or highlight that which applies)*



**Yes No**

**Do you ever lose balance because of dizziness or lose consciousness?**

*(Please tick or highlight that which applies)*



**Yes No**

**If you have answered yes to one or more of these questions RMS Personal Training may need to contact your doctor before you start exercise. If your health changes so that you may then answer yes to any of these questions, please inform RMS Personal Training as soon as possible.**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_