TMCC
Truckee Meadows Community College
Fitness Center

MEDICAL HISTORY

Name: ____ **Male:** ______ **Female:** _____ **DOB:** _____/_____/________

Address: ______________________________________ **City:** _____________________ **State:** ______ **Zip:** __________

Telephone: _______ - _______ - _________ **E-mail:** ____

Select One: Student _______ Faculty _______ Staff _______

If faculty or staff, please complete:

Department: ____ **Office #:** ___________ **Ext.:** _______________

Emergency Contact: _______________________________________ **Relationship:** ______________________________

Telephone: _________ - _________ - _____________

Do you now or have you had in the past:

#	**Condition/History**	**YES**	**NO**
1	History of heart problems, chest pain, or stroke?		
2	Increased blood pressure?		
3	Any chronic illness or condition?		
4	Difficulty with physical exercise?		
5	Advice from a physician not to exercise?		
6	Recent surgery (last 12 months)?		
7	Pregnancy (now or within the last 3 months)?		
8	History of breathing or lung problems?		
9	Muscle, joint or back disorder, or any previous injury still affecting you?		
10	Diabetes or thyroid condition?		
11	Cigarette smoking habit?		
12	Obesity (more tan 20% over ideal body weight?		
13	History of heart problems in immediate family?		
14	Hernia or any conditio that maybe aggravated by lifting weights?		

Please explain any yes answers : ____

____

Health Concerns: ____

____

List any medications you are taking and the reason: ____

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