Harnett Health
Betsy Johnson Hospital
Aquatic-Exercise Program
Medical History Form

Name_____ Age_____

Occupation_____ Doctor_____

Past Medical History

MEDICAL CONDITION	YES	NO	MEDICAL CONDITION	YES	NO
High blood pressure			Kidney disease		
Uncontrolled blood pressure			Seizures		
Heart attack			Osteoporosis		
Cardiac arrhythmia			Diabetes		
Angina			Stroke		
Lung disease			Arthritis		
Cancer			Multiple sclerosis		

For your safety, and that of your fellow classmates, please be aware that any of the following conditions would mean that participation is not appropriate at this time. Please indicate whether you have any of the following conditions:

____incontinence of bowel or bladder
____immune system
____current/recent chemotherapy
____open wounds
____contagious skin disease
____fever
____chemical sensitivity
____urinary infection
____infectious disease
____pregnancy

YOU ARE REQUIRED to let your instructor know if you have , or develop, any of these conditions while participating in the class.

Do you have any medical condition that is not listed above? YES____ NO____
If yes, please list_____
Are you presently taking medication? YES____ NO____
If yes, please list_____
Do you have a pacemaker? YES____ NO____

Participant's Signature_____ Date_____

Witness Signature_____ Date_____