

METABOLIC TESTING PERSONAL DATA SHEET

Please answer the following questions completely. All information is strictly confidential.

Name

Email

Date

Date of Birth

Home Address

Home Phone

Work or Mobile Phone

Height

Weight

Waist Circumference

Emergency Contact

Relationship

Contact Number

MEDICAL INFORMATION

Physician's Name

Physician's Address

List any orthopedic or other significant medical issues:

List all prescription and over-the-counter medications:

	Drug	Dose	Frequency
1			
2			
3			
4			
5			
6			
7			

METABOLIC TESTING PERSONAL DATA SHEET PG 2

List any known drug or substance allergies:

Please respond to the following:

YES

NO

1. I have been told I have hypertension, or systolic BP > 160 or diastolic > 90
2. My total cholesterol is greater than 240 mg/dl
3. I currently smoke or use tobacco products
4. I have diabetes mellitus or have been told that I am pre-diabetic
5. I have a family history of heart disease (parents or siblings prior to age 55)
6. I would describe my lifestyle as sedentary
7. I have been told by a doctor that I have heart disease or a heart murmur, or have experienced any of the following:

Pain or other discomfort that may be due to ischemia in my chest, neck, jaw, or other areas

Shortness of breath at rest or with mild exertion

Dizziness or fainting

Difficulty breathing while lying down or while asleep

Swollen ankles

Fluttering or rapid heart beats

Pain in my legs when walking or exercising

Unusual fatigue or shortness of breath with accustomed activity

OFFICE USE ONLY

RISK STRATIFICATION

Low

Moderate

High

PHYSICIAN SUPERVISION REQUIRED

Yes

No