MEDICAL HISTORY REVIEW FORM

About You

Name:	**Date:**
Address:	
Phone:	**Email:**
Age:	**DOB:**
Emergency Contact Name:	**Emergency Contact Number:**
Relationship:	

COVID-19

Have you had contact with any one who has tested positive for COVID-19 within the past 14 days?	**Yes**	**No**
Have you ever tested positive for COVID-19	**Yes**	**No**
Have you been vaccinated against COVID-19	**Yes**	**No**
If you have been vaccinated have you had 1 or 2 doses?	**1 Dose**	**2 Doses**
I confirm I will notify Jamie within 24 hours if I or anyone I have been in close contact with tests positive for COVID-19	**Yes**	**No**

Medical History

Are you currently under doctors care?	**Yes**	**No**

Do you take any medication?	**Yes**	**No**
If yes please specify the medication you take:		
Have you recently been hospitalised?	**Yes**	**No**
If yes please provide more information:		
Do you smoke/vape?	**Yes**	**No**
Are you or could you be pregnant?	**Yes**	**No**
Have you been pregnant or had a baby within the last 12 months?	**Yes**	**No**
Do you undertake moderate exercise three or more times per week?	**Yes**	**No**
Do you drink alcohol more than three times per week?	**Yes**	**No**
Do you have any of the following conditions:		
High Blood Pressure	**Yes**	**No**
High Cholesterol	**Yes**	**No**
Diabetes	**Yes**	**No**
Please specify you have any other underlying medical conditions that may impact your physical fitness/your ability to exercise:		