TWIIN FLAME
THE POWER TO CREATE

Health History

Name (please print):

Date: **Gender (please circle):** **M** **F** **Age:**

Physician's Name: **Phone:**

Person to contact in case of emergency:

Name: **Relationship:**

Phone Numbers:

1. **Are you taking any prescription or non-prescription medications at this time? Please list.**

_____

2. **Have you used alcohol or non-prescription drugs in the past 7 days?**

_____

3. **Do you now, or have in the past:** **Yes**

   i) History of heart problems, chest pain or stroke _____

   ii) Diagnosed high blood pressure (140/90mmHg.) _____

   iii) Any chronic illness or condition _____

   iv) Recent surgery (last 12 months) _____

   v) Pregnancy (now or within last 3 months) _____

   vi) History of breathing or lung problems _____

   vii) Muscle, joint, or back disorder, or any previous injury still affecting you _____

   viii) Diabetes condition _____

   ix) Thyroid condition _____

   x) Cigarette smoking habit _____

   xi) High blood cholesterol (22mg./dl or above) _____

   xii) Difficulty with physical exercise _____

   xiii) Allergies _____

   Please explain any Yes answer on page 2.

If in the event of a medical emergency 000 is called on my behalf, I agree to go with the paramedics in the ambulance to the hospital.

_____ _____

Signature: **Date:**

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‘Please explain any Yes answer’