

**Sunnyview Lifestyle Wellness Center
Health History- YOGA CLASSES**

Name: _____ **Age:** _____ **DOB:** __/__/__

Address: _____

Phone: home _____ **work** _____ **e-mail** _____

Emergency Contact _____ **Phone** _____

Physician: _____ **Last seen:** _____ **Phone:** _____

CHECK THOSE THAT APPLY, (with date/ effect of condition, if appropriate)

Heart attack, cardiac surgery, or stroke _____

Irregular or skipped heart beats _____

Pulmonary Disease (COPD, Asthma) _____

Seizures _____

Vertigo, loss of balance, Dizziness _____

Currently smoking _____ packs per day Quit? _____ Date: _____

Diabetes Mellitus _____

Blood Clot/ Deep Vein Thrombosis _____

High Blood Pressure _____

High Cholesterol _____

Fibromyalgia _____

Osteoporosis/Osteopenia _____

Untreated Medical Condition _____

Thyroid disorder _____

Arthritis _____

Orthopedic limitation or injury _____

Chronic Pain _____

Other _____

Sleep Quality? _____ Height: _____ Weight: _____

Previous Hospitalizations: Medical/ surgical- date _____

Psychological- date _____

Please list medications and reason/ conditions for medication:

Please list current wellness and/or exercise activities: _____

Please list your three goals for participating in this program: 1) _____

2) _____ 3) _____

