In order to submit this form, you should open it with Adobe Acrobat Reader.

GAINZ

Medical History Form

Full Name

First Name Last Name

What is your age?

What is your gender?

Please Select

Contact Number

Email Address

example@example.com

Check the conditions that apply to you or any member of your immediate relatives:

- Asthma
- Cardiac disease
- Hypertension
- Epilepsy
- Cancer
- Diabetes
- Psychiatric disorder
- Other

Check the symptoms that you' re currently experiencing:

- Chest pain
- Hematological
- Gastrointestinal
- Respiratory
- Lymphatic
- Genitourinary
- Cardiac disease
- Neurological
- Weight gain
- Cardiovascular
- Psychiatric
- Weight loss

Jotform

Now create your own Jotform PDF document - It's Free Create your own PDF Document

☐ Musculoskeletal

☐ Other

Are you currently taking any medication?

◉ Yes ○ No

Do you have any medication allergies?

◉ Yes ○ No ○ Not Sure

Do you use any kind of tobacco or have you ever used them?

Please Select

How often do you consume alcohol?

○ Daily ○ Weekly ○ Monthly ○ Occasionally ○ Never

Jotform Now create your own Jotform PDF document - It's Free Create your own PDF Document