

Federal Deposit Insurance Corporation  
**MEDICAL HISTORY QUESTIONNAIRE**

**SECTION I – GENERAL INFORMATION**

1. Name <i>(Last, First, MI)</i>	2. Age	3. Date of Birth	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
5. Division/Office		6. Work Phone Number/Ext.	7. Home Phone Number

**SECTION II – EMERGENCY CONTACT INFORMATION**

8. Name	9. Relationship	10. Home Phone Number	11. Office Phone Number
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**SECTION III – PHYSICIAN INFORMATION**

12. Physician's Name	13. Physician's Phone Number
14. Street Address <i>(Street Number, Suite/Room Number, City, State, and ZIP Code)</i>	

**SECTION IV – HEALTH QUESTIONS**

15. Please check the appropriate box(es) to indicate whether you have or have had any of the following:

- |   |   |                                   |   |
|---|---|-----------------------------------|---|
| <input type="checkbox"/> Heart Problems/Circulation | <input type="checkbox"/> High Blood Pressure              | <input type="checkbox"/> Asthma   | <input type="checkbox"/> Migraine Headaches   |
| <input type="checkbox"/> Chest Pains                | <input type="checkbox"/> Low Blood Pressure               | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Bone/Joint Problems (such as arthritis that have been aggravated by exercise or might be made worse with exercise) |
| <input type="checkbox"/> Heart Attack               | <input type="checkbox"/> Dizzy Spells/History of Fainting | <input type="checkbox"/> Epilepsy |   |
| <input type="checkbox"/> Back Problems              | <input type="checkbox"/> Ulcers                           | <input type="checkbox"/> Diabetes |   |

16. Date of last Exam	17. Are you accustomed to exercising? <input type="checkbox"/> No <input type="checkbox"/> Yes	18. Do you smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes	19. Do you have any allergies <i>(Specify)</i>
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20. List all prescription and over the counter medicine taken on a regular basis or more than once a week.

21. Illness(es) under M.D.'s care <i>(Specify)</i>	22. Have you had any injuries/surgery? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(If yes, explain under Comments.)</i>
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COMMENTS

23. Is there any medical or physical reason not mentioned above that would prevent you from participating in an exercise program?  No  Yes *(If yes, explain below.)*

The FDIC is authorized to request this information from you by 12 U.S.C § 1819. The main purpose for collecting the information is to help assess and sustain your fitness for use of the FDIC Fitness Center. Furnishing the requested information is voluntary, but failure to provide the requested information may delay or prohibit your membership and participation in the FDIC Fitness Center. The information you provide may be furnished to third parties, including law enforcement authorities, as authorized by law, or used according to any of the routine uses described in the FDIC Fitness Center Records (30-64-0021) System of Records.