LIFECYCLE(MALTA) FOUNDATION

LIFECYCLE CHALLENGE

MEDICAL FORM

This form has to be completed prior to acceptance on the Challenge. No medical examination by a doctor is required.

Name _____ Date_____

Address_____

Mob Phone _____ Phone(work)_____Phone (home)_____

Age_____ Birth date_____

Gender: Male Female Current Weight_____

Occupation_____ Employer_____

Name of emergency contact_____ Relationship_____

Address _____

Mobile Phone _____ Phone (home) _____

Primary Care Physician_____ Phone _____

How would you describe your health?

_____

Are you currently receiving any medical treatment? If so please give details.

_____

Have you had any operations in the last 5 years? If so please give details

_____

Have you suffered from an eating disorder? If so please give details

_____

Do you have any or have you had any of the following conditions? If so please explain

Hear Attack Stroke Chest pains Hypertension Cancer
High Cholestrol Diabetes Thyroid problems Arthritis Anemia
Obesity Other:_____

Have you ever been advised by a health-care professional not to diet. Yes/No if yes, please explain

_____

Do you know of any reason why you should not diet? Yes/No. If yes, please explain.

_____

The information I have provided on this form is, to the best of my knowledge, complete and accurate.

Signature_____

Printed Name_____