

HEALTH HISTORY FORM



NAME _____

DATE _____

BIRTHDATE _____ AGE _____ SEX FEMALE MALE

PHYSICIAN'S NAME _____ PHONE (____) _____

PERSON TO CONTACT IN CASE OF EMERGENCY: NAME: _____

RELATIONSHIP: _____ PHONE(S) (____) _____ (____) _____

Are you taking any medications or drugs? If so, please list medication, dose and reason.

Does your physician know you are participating in this program? _____

Describe any physical activity you do somewhat regularly. _____

Do you now have, or have you in the past had, any of the following? Check any that apply.

- ____ 1. History of heart problems, chest pain or stroke
- ____ 2. Abnormal blood pressure
- ____ 3. Any chronic illness or condition
- ____ 4. Difficulty with physical exercise
- ____ 5. Advice from physician not to exercise
- ____ 6. Recent surgery (within last 12 months)
- ____ 7. Pregnancy (now or within last 3 months)
- ____ 8. History of breathing or lung problems
- ____ 9. Muscle, joint or back disorder, or any previous injury still affecting you
- ____ 10. Diabetes or thyroid condition
- ____ 11. Cigarette or other smoking habit
- ____ 12. Obesity (more than 20% over ideal body weight)
- ____ 13. High cholesterol
- ____ 14. History of heart problems in immediate family
- ____ 15. Hernia or any conditions that could be aggravated by lifting weights

Please explain any areas that you checked. _____

Is there anything else you want to share that would help us as we help you reach your fitness goals? _____

Continue on reverse side of this page, if necessary.