

## Health History Form

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Sex  M  F

Physician's Name \_\_\_\_\_

Physician's Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Person to contact in case of Emergency:

Name \_\_\_\_\_ Phone \_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

Describe any physical activity you do somewhat regularly.

\_\_\_\_\_

<i>Do you now, or have you had in the past:</i>		YES	NO
1.	History of heart problem, chest pain, or stroke	<input type="checkbox"/>	<input type="checkbox"/>
2.	Increased blood cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
3.	Any chronic illness or condition	<input type="checkbox"/>	<input type="checkbox"/>
4.	Difficulty with physical exercise	<input type="checkbox"/>	<input type="checkbox"/>
5.	Advice from physician not to exercise	<input type="checkbox"/>	<input type="checkbox"/>
6.	Recent surgery (last 12 months)	<input type="checkbox"/>	<input type="checkbox"/>
7.	Pregnancy (now or within last 3 months)	<input type="checkbox"/>	<input type="checkbox"/>
8.	History of breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/>
9.	Muscle, joint, or back disorder, or any previous injury still affecting you	<input type="checkbox"/>	<input type="checkbox"/>
10.	Diabetes or thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>
11.	Cigarette smoking habit	<input type="checkbox"/>	<input type="checkbox"/>
12.	Obesity (more than 20% over ideal body weight)	<input type="checkbox"/>	<input type="checkbox"/>
13.	Increased blood cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
14.	History of heart problems in immediate family	<input type="checkbox"/>	<input type="checkbox"/>
15.	Hernia, or any condition that may be aggravated by lifting weights	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "YES" answers on the back.

Comments:

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