Health History Form

Name: _____

Address: _____

Home phone: _____ Work phone: _____

Date of birth: _____ Occupation: _____

Height (cm): _____ Weight (kg): _____ BMI: _____ [BMI = wt (kg)/ht $(m)^2$]

Fat mass (kg): _____ Fat-free mass (kg): _____

Blood pressure: Systolic _____mmHg Diastolic _____mmHg Pulse: _____BPM

Cardiovascular Risk

Please mark each statement that is true.

_____ You are a man over the age of 45 years.

_____ You are a woman over the age of 55 years.

_____ You are physically inactive (active less than 30 minutes three times a week).

_____ You are overweight (9 kg [20 lb] or more, or BMI over 30).

_____ You presently smoke or have quit within the past six months.

_____ You have high blood pressure or take blood pressure medication.

_____ You have been told you have high cholesterol.

_____ Your father or brother had a heart attack or heart surgery before the age of 55.

_____ Your mother or sister had a heart attack or heart surgery before the age of 65.

Existing Medical Conditions

Please check the appropriate conditions.

_____ Anemia
_____ Arthritis
_____ Asthma
_____ Cholesterol
_____ Diabetes
_____ Epilepsy
_____ Heart condition
_____ Hernia
_____ Obesity
_____ Pregnancy
_____ Thyroid problems
_____ Ulcer
_____ Other: _____
_____
_____

Medications

Are you currently taking any medications? _____ Yes _____ No

If yes, please list the condition and what medication is required.

Condition: _____ Medication: _____

Condition: _____ Medication: _____

Condition: _____ Medication: _____

Condition: _____ Medication: _____

> continued

Allergies

Do you have any allergies? _____ Yes _____ No

If yes, please list and indicate whether medication is required.

Allergy: _____ Medication required: _____

Allergy: _____ Medication required: _____

Injuries

Do you have pain, or have you injured any of the following areas?

_____ Neck	_____ Shoulder: R, L	_____ Hip: R, L
_____ Upper back	_____ Elbow: R, L	_____ Knee: R, L
_____ Lower back	_____ Wrist: R, L	_____ Ankle R, L

Please explain: _____

Exercise Habits

_____ Intensive occupational and recreational exertion
_____ Moderate occupational and recreational exertion
_____ Sedentary work and intense recreational exertion
_____ Sedentary work and moderate recreational exertion
_____ Sedentary work and light recreational exertion
_____ Complete lack of occupational or recreational exertion

Is there any reason why you can't exercise regularly? _____ Yes _____ No

Explain: _____

Lifestyle

	Always	Sometimes	Rarely
I get seven to eight hours of sleep per night.	_____	_____	_____
I am physically active three times a week.	_____	_____	_____
I have regular medical checkups.	_____	_____	_____
I eat three to five servings of vegetables daily.	_____	_____	_____
I eat two to four servings of fruit daily.	_____	_____	_____
I eat six to ten servings of grains and cereals daily.	_____	_____	_____
I eat two to three servings of meats and nuts daily.	_____	_____	_____
I make a conscious effort to eat healthy.	_____	_____	_____
I follow a strict diet.	_____	_____	_____
I have no stress in my life.	_____	_____	_____
I am a very happy person.	_____	_____	_____
I am highly motivated.	_____	_____	_____

Goals

	Goal	Time frame	Commitment
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Family Physician

Name: _____

City: _____

Phone number: _____

Contact in Case of Emergency

Name: _____

Phone number: _____

Relation: _____

Personal Training Specialist

By signing this form, I certify that I have asked for and understand the pertinent information required for me to make an informed decision.

Signature: _____ Date: _____

Client

By signing this form, I certify that I have fully disclosed all pertinent information in an honest and truthful manner.

Signature: _____ Date: _____

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