Health History Form

Name _____ Date _____
Address_____ Phone _____
Date of birth _____ Email_____ Weight_____
In case of emergency, contact: _____ Relationship_____
Date of last physician checkup: _____
Are you currently under a doctor's care? □ Yes □ No
If yes, explain: _____
Do you take any medications on a regular basis? □ Yes □ No
If yes, please list medications and reasons for taking: _____

Please check any conditions below that applies to you:

High blood pressure	□ Yes □ No
Diabetes	□ Yes □ No
Heart attack	□ Yes □ No
Stroke	□ Yes □ No
High cholesterol	□ Yes □ No
Have known heart disease	□ Yes □ No
Rheumatic heart disease	□ Yes □ No
Heart murmur	□ Yes □ No
Chest pain with exertion	□ Yes □ No
Irregular heartbeat or palpations	□ Yes □ No
Lightheadedness or fainting	□ Yes □ No
Emphysema	□ Yes □ No
Other metabolic disorder (thyroid, kidney, etc.)	□ Yes □ No
Epilepsy	□ Yes □ No
Asthma	□ Yes □ No
Back pain: upper, middle, lower	□ Yes □ No
Other joint pain (explain)	□ Yes □ No
Muscle pain or injury (explain)	□ Yes □ No

I attest that the above information is true to the best of my knowledge and acknowledge that I understand the information will be utilized for fitness assessment purposes. I realize that if the information is incorrect it may result in harm to me.

Signature _____ Date_____