HEALTH HISTORY QUESTIONNAIRE

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, supplements, or drugs? If so, please list medication, dose, and reason:

_____

_____

_____

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

_____

Describe any physical activity you do somewhat regularly.

_____

_____

Do you now have, or have you had in the past:	YES	NO
1. History of heart problems, chest pain, or stroke	☐	☐
2. Elevated blood pressure	☐	☐
3. Any chronic illness or condition	☐	☐
4. Difficulty with physical exercise	☐	☐
5. Advice from physician not to exercise	☐	☐
6. Recent surgery (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 metabolic syndrome	☐	☐
11. Thyroid condition	☐	☐
12. Cigarette smoking habit	☐	☐
13. Elevated blood cholesterol	☐	☐
14. History of heart problems in immediate family	☐	☐
15. Hernia, or any condition that may be aggravated By lifting weights or other physical activity	☐	☐