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. Obesity [body mass index (BMI) ≥30 kg/m^2]	❑	❑
14. Elevated blood cholesterol	❑	❑
15. History of heart problems in immediate family	❑	❑
16. Hernia, or any condition that may be aggravated by lifting weights or other physical activity	❑	❑