DATE:		 	



Lifestyle and Medical History Questionnaire

Athlete	Athlete Last Name:Athlete First Name:					
<u>Medic</u>	al Information:					
Please condit		ou (past o	r present) and list any importar	nt informa	ation about your	
☐ (Speci	Allergies fy:)		Diabetes	☐ (IBS)	Irritable bowel syndrome	
	Angina		Low Blood pressure		Menopausal symptoms	
	Anemia		Heart Attack		Multiple Sclerosis	
	Arthritis		High blood pressure		Osteoporosis	
	Asthma		Heart Disease		Pregnant	
	Cancer		High cholesterol	(PCOS)	Polycystic ovary syndrome	
	Chronic sinus		Hypoglycemia		Stroke	
condit	ion					
	Crohn's disease		Hypo/hyperthyroidism		Skin problems	
	COPD		Intestinal problems		Respiratory disease	
Describe any other health condition you have that is not listed:						
Any important information about your condition (if it applies):						
Please list any injuries that may interfere with exercising (past or present):						
Please list any major surgeries:						

<u>Family</u>	History	<u>/:</u> Has anyone in you	immediate family been diagnosed with the following?		
		Heart Disease	If yes, what relation:		
		☐ High cholesterol If yes, what relation:			
	☐ High blood pressure If yes, what relation:				
		Cancer	If yes, what relation:		
		Diabetes	If yes, what relation:		
		Osteoporosis	If yes, what relation:		
		Stroke	If yes, what relation:		
Medica	ations:				
1.	Are you taking any prescribed medications?				
	Do these interact with any physical activity?				
2.	Do you take any over-the-counter medication?				
	If yes, v	vhat medication?			
Lifesty	le and H	Habits:			
1.	Do you participate in any structured physical activity? Yes No				
	If so, please describe: minutes of cardiovascular activity, times per wee				
	At what	t intensity are the car	rdiovascular sessions? Low Moderate High		
			nutes of strength-training, times per week		
			nutes of flexibility training, times per week		
		mi	nutes of sports per week		
	List spo	ort(s):			