Health and Medical Questionairre

Date: _____

Name: _____ Date of birth: _____

Address: _____

Street City State Zip

Phone (H): _____ (W): _____ E-mail address: _____

In case of emergency, whom may we contact?

Name: _____ Relationship: _____

Phone (H): _____ (W): _____

Personal physician

Name: _____ Phone: _____ Fax: _____

Present/Past History

Have you had OR do you presently have any of the following conditions? (Check if *yes*.)

___ Rheumatic fever
___ Recent operation
___ Edema (swelling of ankles)
___ High blood pressure
___ Injury to back or knees
___ Low blood pressure
___ Seizures
___ Lung disease
___ Heart attack
___ Fainting or dizziness with or without physical exertion
___ Diabetes
___ High cholesterol
___ Orthopnea (the need to sit up to breathe comfortably) or paroxysmal (sudden, unexpected attack) nocturnal dyspnea (shortness of breath at night)
___ Shortness of breath at rest or with mild exertion
___ Chest pains
___ Palpitations or tachycardia (unusually strong or rapid heartbeat)
___ Intermittent claudication (calf cramping)
___ Pain, discomfort in the chest, neck, jaw, arms, or other areas with or without physical exertion
___ Known heart murmur
___ Unusual fatigue or shortness of breath with usual activities
___ Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side, arm, or leg of your body
___ Other

Family History

Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions? (Check if *yes*.) In addition, please identify at what age the condition occurred.

___ Heart arrhythmia
___ Heart attack
___ Heart operation
___ Congenital heart disease
___ Premature death before age 50
___ Significant disability secondary to a heart condition
___ Marfan syndrome
___ High blood pressure
___ High cholesterol
___ Diabetes
___ Other major illness _____

Explain checked items: _____

_____

_____

Activity History

1. How were you referred to this program? (Please be specific.) _____

   _____

   _____

2. Why are you enrolling in this program? (Please be specific.) _____

   _____

   _____

3. Are you presently employed? Yes ___ No ___
4. What is your present occupational position? _____
5. Name of company: _____
6. Have you ever worked with a personal trainer before? Yes ___ No ___
7. Date of your last physical examination performed by a physician:
8. Do you participate in a regular exercise program at this time? Yes ___ No ___ If yes, briefly describe:

   _____

   _____

9. Can you currently walk 4 miles briskly without fatigue? Yes ___ No ___
10. Have you ever performed resistance training exercises in the past? Yes ___ No ___
11. Do you have injuries (bone or muscle disabilities) that may interfere with exercising? Yes ___ No ___ If yes, briefly describe: _____

    _____

    _____

12. Do you smoke? Yes ___ No ___ If yes, how much per day and what was your age when you started?

    Amount per day _____ Age _____
13. What is your body weight now? ____ What was it one year ago? ____ At age 21? ____
14. Do you follow or have you recently followed any specific dietary intake plan, and in general how do you feel about your nutritional habits? _____

    _____

15. List the medications you are presently taking. _____

    _____

    _____

16. List in order your personal health and fitness objectives.

    a. _____

    _____

    b. _____

    _____

    c. _____

    _____