

Health History Questionnaire

This Form and Your Confidentiality

This health history form is your opportunity to provide information that will assist our fitness professionals in evaluating your current level of health and fitness. This form and the information you provide will be kept in a manner that assures your confidentiality. Any information you provide will be available only to the fitness professional and will be used solely in conjunction with planning and developing health and fitness programs.

Basic Information (please print)

Last Name:		Today's Date:	
First Name:		Date of Birth:	
Age:	Height:	Weight:	
Employer Information:			
Primary Physician's Name			
Primary Physician's Address			
Primary Physician's Phone No.			

Health History

Please indicate your history related to each of the following conditions by checking the appropriate box. If you have had any condition in the past, please indicate the date in the appropriate space.

Condition	Never	Now	Have Had (Date)
Heart murmur, clicks, or other cardiac findings			
Frequent extra, skipped, or rapid heart beats/palpitations			
Heart attack, coronary bypass, or other cardiac surgery			
Chest pain/angina (especially upon exertion)			
Currently pregnant			
Diagnosed with high blood pressure			
Leg cramps during exercise			
Chronic swollen ankles			
Varicose veins			
Frequent dizziness/fainting			
Blood clot			
Severe arthritis			
Orthopedic problem(s) or complaint(s)			
Chronic back pain			
Musculoskeletal problems(s) or complaint(s)			
Asthma			
Cancer			
Diabetes			
Epilepsy			
Rheumatic Fever			
Scarlet Fever			
Bronchitis			
Stroke			
Pneumonia			

Health History Questionnaire (continued)

Recent Surgery (Please describe and give dates.)

Other medical problems/considerations, recent illness(es), hospitalizations(s), or injury

Current medications/prescriptions

Do you smoke? _____

Date of last complete medical or physical exam: _____

Do you know of any medical or health conditions, considerations, or circumstances that might make it dangerous or unwise for you to participate in an exercise program?

Family Health History

Please indicate the number of blood relatives (mother, father, grandparents, brothers, sisters, children) who have had a heart attack prior to age 65 _____

have had a stroke _____

have had or now have diabetes _____

have been or are substantially overweight _____

The information submitted on this Health History Form is true and complete to the best of my knowledge, and I understand that any wrong or incomplete information could result in a less effective fitness program, injury, or illness.

Signature

Print Name

Date