

# Health History Form

This health history is my primary tool for developing a safe, effective training program for you. The information is personal and will be held confidential. *Please answer honestly and accurately.*

## Demographic Information

Name \_\_\_\_\_ Date \_\_\_\_\_

Mailing address \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Email address \_\_\_\_\_

Age \_\_\_\_\_ Birthday \_\_\_\_\_ Height \_\_\_\_\_ Gender (circle one) F M

Physician's name \_\_\_\_\_ Physician's phone number \_\_\_\_\_

Person to contact in case of an emergency

_____	_____	_____
Name	Relationship	Phone number

Does your physician know you are participating in this exercise program? \_\_\_\_ yes \_\_\_\_ no

## Medications

Are you taking any medications, drugs, or supplements? \_\_\_\_ yes \_\_\_\_ no

If yes, please list medication, dose, and reason.

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## Exercise History

Describe any physical activity you do somewhat regularly. List what type of activity you do, how many times per week you do it, and how long you do it.

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# Health History Form (page 2)

## Health Risk Factors

Do you now, or have you had in the past:

- | YES                      | NO                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. History of heart problems, chest pain, or stroke                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Increased blood pressure (> 140 mmHg [systolic] or > 90 mmHg [diastolic])        |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Any chronic illness or condition, such as cancer                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Difficulty with physical exercise  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Advice from physician not to exercise  |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Recent surgery (within last 12 months)   |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Pregnancy (now or within last 3 months)  |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. History of breathing or lung problems, such as asthma, bronchitis, and emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Arthritis  |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Osteoporosis  |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Muscle, joint, or back disorder, or any previous injury still affecting you     |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Diabetes or thyroid condition   |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Cigarette smoking habit   |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Obesity (more than 20 percent over ideal body weight)                           |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Increased blood cholesterol (> 240 mg/dL)                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. History of heart problems in immediate family                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. Hernia or any condition that may be aggravated by lifting weights               |

Please explain any “yes” answers below.

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*If you answered “yes” to one or more of the questions above, you may be at increased risk for injury during exercise and should obtain a physician’s release before becoming more physically active or having a fitness assessment.*

Do you have any other physical/health conditions that may limit your participation? \_\_\_\_\_ yes \_\_\_\_\_ no  
If yes, please explain.

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# Health History Form (page 3)

## Family History

Does anyone in your family (mother, father, sibling, grandparent, aunt, or uncle) have any history of the following:

- | YES                      | NO                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Heart disease  |
|                          |                          | If yes, who? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Increased blood pressure (> 140 mmHg [systolic] or > 90 mmHg [diastolic])        |
|                          |                          | If yes, who? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Cancer   |
|                          |                          | If yes, who? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. History of breathing or lung problems, such as asthma, bronchitis, and emphysema |
|                          |                          | If yes, who? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Arthritis  |
|                          |                          | If yes, who? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Osteoporosis   |
|                          |                          | If yes, who? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Diabetes   |
|                          |                          | If yes, who? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Obesity  |
|                          |                          | If yes, who? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Increased blood cholesterol (> 240 mg/dL)  |
|                          |                          | If yes, who? _____  |

## Signature

I have read, understood, and completed this health history form. The above information is true to the best of my knowledge. Any questions I had were answered to my full satisfaction.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date