



Health History Form

Name _____

Date _____

Mailing Address _____

Phone _____ Cell _____ Work _____

Email Address _____

Age _____ Birth Date _____ Sex M F

Medical Professional's Name _____

Medical Professional's Phone# _____

Person to contact in case of Emergency: _____

Emergency contact Phone # _____

Relationship of Emergency contact: _____

Are you taking any medications or drugs? If so please list medication, dose, reason, and how long you've been on the medication. _____

1. _____ Reason _____

2. _____ Reason _____

3. _____ Reason _____

4. _____ Reason _____

5. _____ Reason _____

Does your medical professional know you are participating in an exercise program?

Yes No

Do you now, or have you had in the past: (check if yes. Leave blank if no)

1. History of heart problems, chest pain or stroke
2. Increased 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 disease (thyroid renal, liver)
11. Cigarette smoking habit or Tobacco use
12. Obesity (more than 20 percent over ideal body weight)
13. Increased blood cholesterol
14. History of heart problems in immediate family
15. Hernia or any condition that may be aggravated by lifting weights

Please explain any "yes" answers below and on the back of this page. Place the number of the "Yes" before the explanation.

Comments:

Blood Pressure Screening (for trainer use):

Systolic

Diastolic

Resting Heart Rate

Creating Optimal Results Everyday