



Health History Form

Name _____ Date _____

Sex M F Age _____ Phone _____ Email _____

Physician's Name _____

Physician's Contact information _____

Person to contact in case of emergency:

Name _____ Phone _____

Are you taking any medications or drugs? If so, please list medication, dose, and reason.

Does your physician know you are participating in this exercise program?

Describe any physical activity you do somewhat regularly.

<i>Do you now, or have you had in the past:</i>	YES	NO
1. History of heart problems, chest pain, or stroke.	<input type="checkbox"/>	<input type="checkbox"/>
2. Increased blood pressure.	<input type="checkbox"/>	<input type="checkbox"/>
3. Any chronic illness or condition	<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 (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	<input type="checkbox"/>	<input type="checkbox"/>
9. Muscle, joint, or back disorder, or any previous injury still affecting you	<input type="checkbox"/>	<input type="checkbox"/>
10. Diabetes or thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>
11. Cigarette smoking habit	<input type="checkbox"/>	<input type="checkbox"/>
12. Obesity (more than 20% over ideal body weight)	<input type="checkbox"/>	<input type="checkbox"/>
13. Increased blood cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
14. History of heart problems in immediate family	<input type="checkbox"/>	<input type="checkbox"/>
15. Hernia, or any condition that may be aggravated by lifting weights	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "YES" answers on back.

Comments:
