

HEALTH HISTORY QUESTIONNAIRE

NAME: _____ Phone: _____

DATE OF BIRTH: _____ EMAIL: _____

Person & Phone Number to Contact in Case of Emergency:

Yes No

- Have you talked to your doctor about your participation in this exercise program?
- Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
- Is your doctor currently prescribing drugs for your blood pressure or a heart condition?
- Are you taking any medications that may affect your vital signs (ie: blood pressure or heart rate) or physical performance?

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

- † History of heart problems, chest pain, or stroke
- † Elevated blood pressure
- † Elevated blood cholesterol
- † Any chronic illness or condition
- † Difficulty breathing/shortness of breath
- † Dizziness or fainting spells
- † Diabetes
- † Muscle, bone, joint, or back disorder, or any previous injury still affecting you
- † Any injuries or orthopedic problems
- † Recent surgery (last 12 months)
- † Pregnancy (now or within last 6 months)
- † Obesity
- † Hernia, or any condition that may be aggravate by lifting weights

Please explain any 'yes' answers:

Do you currently exercise? Yes No

If so, of what does your program consist? Weights Cardio Pilates Yoga Other

I have read, understood, and completed this Health History Questionnaire.
I acknowledge, to the best of my ability, that the above is true and accurate.

SIGNATURE: _____

DATE: _____