

# Health History

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Local Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Height: \_\_\_\_\_ Age: \_\_\_\_\_

Gender: \_\_\_\_\_ Occupation: \_\_\_\_\_

1) Do you smoke? \_\_\_\_\_ How Often? \_\_\_\_\_

2) Do you use alcohol? \_\_\_\_\_ How often? \_\_\_\_\_

3) So you have high blood pressure? **Y** or **N** what were the last three readings?

\_\_\_\_ / \_\_\_\_ ; \_\_\_\_ / \_\_\_\_ ; \_\_\_\_ / \_\_\_\_

4) Do you have any cardiovascular problems or disease? **Y** or **N**

Explain

\_\_\_\_\_  
\_\_\_\_\_

5) Have you experienced chest pain when doing physical activity? **Y** or **N**

6) Do you lose consciousness or lose balance because of dizziness? **Y** or **N**

7) Are you pregnant or post-partum? **Y** or **N**

8) Do you have diabetes? **Y** or **N** Explain

\_\_\_\_\_  
\_\_\_\_\_

9) Have you had surgery within the last 2 Years? **Y** or **N** Explain

\_\_\_\_\_  
\_\_\_\_\_

10) Are you taking any medications? Y or N Explain

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11) Are you taking any supplements or vitamins? Y or N Explain

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12) When were you last seen by a physician? \_\_\_\_\_

13) Do you have any injuries or orthopedic problems?

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14) Have you been told you have high cholesterol levels? \_\_\_\_\_

15) Please circle all conditions that you have or have had in the past.

- a. Heart attack
- b. Diabetes
- c. Stroke
- d. Chest discomfort
- e. Heart mermur
- f. Trouble sleeping
- g. Migraine or headache
- h. Neck problems
- i. Back problems
- j. Broken bones
- k. Shortness of breath
- l. Anemia
- m. Asthma
- n. Epilepsy
- o. Anxiety or depression
- p. Fatigue
- q. Hernia
- r. Stomach problems
- s. Limited range of motion
- t. Arthritis
- u. Swelling of joints

16) Please, explain any conditions that you checked:

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17) Have you in the past or currently had/have any medical conditions or problems not previously mentioned? Explain?

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I acknowledge that I am in good health, have answered the previous questions truthfully, and have no known medical problems that would preclude safe participation in this exercise program.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_