

### Health History Form

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

Age: \_\_\_\_\_ Sex: M or F

Physician's Name: \_\_\_\_\_

Physician's Phone: (\_\_\_\_) \_\_\_\_\_

Person to contact in case of Emergency:

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

Phone: (\_\_\_\_) \_\_\_\_\_

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

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

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Describe any physical activity you do somewhat regularly.

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

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 14 months)
8. History of breathing or lung problems
9. Muscle, joint or back disorder, or any previous injury still affecting you
10. Diabetes or thyroid condition
11. Cigarette smoking habit
12. Obesity (more the 20 percent over ideal body weight)

Yes No

Yes	No

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

13. Increased blood cholesterol

14. History of heart problems in immediate family

15. Hernia, or any condition that may be aggravated by lifting weights

Yes No


Please explain any "yes" answers:

Comments:

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Signed:

Date:

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Fitness Professional:

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