



Health History Form

Name _____ Date _____

Age _____ Date of Birth _____ Sex M or F

Physician's Name _____ Phone _____

Person to Contact in Case of Emergency _____

Relationship _____ Phone _____

Are you taking any medications or drugs including diet pills, vitamin or mineral supplements, birth control pills or herbal remedies? Yes No Please list below.

Medication Dose Reason

Does your physician know you are participating in this exercise program? Yes No

Describe any physical activity you do regularly - type, frequency, duration, and intensity.

Describe any physical activities you have done in the past.

Do you now or have you had in the past?	Yes	No
1. History of heart problems, chest pain or stroke	<input type="checkbox"/>	<input type="checkbox"/>
2. Increased blood pressure		<input type="checkbox"/>
3. Any chronic illness or condition		<input type="checkbox"/>
4. Difficulty with physical exercise		<input type="checkbox"/>
5. Advice from a physician not to exercise		<input type="checkbox"/>
6. Recent surgery (last 12 months)		<input type="checkbox"/>
7. Pregnancy (now or within last 3 months)		<input type="checkbox"/>
8. History of breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/>
9. Muscle, joint or back disorder	<input type="checkbox"/>	<input type="checkbox"/>
10. Any previous injury still affecting you	<input type="checkbox"/>	<input type="checkbox"/>
11. Diabetes or thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>
12. Cigarette smoking habit		<input type="checkbox"/>
13. Obesity (more than 20% over ideal body weight)		<input type="checkbox"/>
14. Increased blood cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
15. History of heart disease in immediate family		<input type="checkbox"/>
16. Hernia	<input type="checkbox"/>	<input type="checkbox"/>
17. Other health concerns		<input type="checkbox"/>

Please explain any "yes" answers. Use the back of the page, if necessary.

Signature _____ Date _____