



HEALTH HISTORY

Date: _____

Name: _____ Age: _____

Emergency Contact: _____
(Name and Telephone Number, including area code)

Do you now, or have you had in the past (mark all that apply):

- History of heart problems, chest pain, or stroke
- High blood pressure
- High blood cholesterol
- Any chronic illness or condition
- Difficulty with physical exercise
- Advice from physician not to exercise
- Recent Surgery (past 12 months)
- Pregnancy (now or within past 3 months)
- History of breathing or lung problems
- Cigarette smoking habit
- Muscle, joint, or back disorder (or any previous injury still affecting you)
- Hernia (or any condition that may be aggravated by lifting weights)
- Diabetes or thyroid condition
- Cigarette smoking habit
- History of heart problems in immediate family

If any of the above is checked, please explain further and indicate any recommendations your doctor has made regarding exercise.

What best describes your level of physical activity during the past 4-6 weeks?

- Very Active Moderately Active Occasionally Active Inactive

Describe any physical activity you do somewhat regularly.

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

Please indicate any additional exercise or medical information which you think may be important for your trainer to know prior to fitness testing or exercise
