Health History

NAME: ______________________________ **AGE:** ______ **DATE OF BIRTH:** ____________________________
Have you previously been tested for an exercise program? ___Y ___N **Last test:** _________________

HOME PHONE #_____________________________ **CELL PHONE:**____

PRIMARY PHYSICIAN: ____
PYSICIAN PHONE #: ____________________________ **FAX #:** ______________________________________

SPECIALIST (*PT, Cardiologist, etc.)*: ____
SPECIALIST PHONE #: ____________________________ **FAX #:** ____________________________________

In case of emergency, contact: ___________________________________ **PHONE#:** _______________________

PLEASE CHECK YES or NO

PAST HISTORY

(Have you ever had?)	**YES**	**NO**
High blood pressure............	☐	☐
Any heart trouble................	☐	☐
Disease of the arteries.......	☐	☐
Lung disease......................	☐	☐
Asthma..............................	☐	☐
Hepatitis............................	☐	☐
Diabetes............................	☐	☐
Heart murmur.....................	☐	☐
Arthritis.............................	☐	☐

FAMILY HISTORY

(Have any of your immediate family or grandparents had?)	**YES**	**NO**
Heart attacks......................	☐	☐
High blood pressure............	☐	☐
High cholesterol.................	☐	☐
Stroke................................	☐	☐
Diabetes............................	☐	☐
Congenital heart defect.......	☐	☐
Heart operations.................	☐	☐
Other family illness......................................		
....		

PRESENT SYMPTOMS

(Have you recently had?)	**YES**	**NO**
Chest pain/discomfort........	☐	☐
Shortness of breath............	☐	☐
Heart palpitations...............	☐	☐
Irregular heart beats...........	☐	☐
Frequent headaches..........	☐	☐
Dizzy spells........................	☐	☐
Frequent colds...................	☐	☐
Back pain...........................	☐	☐
Orthopedic problems..........	☐	☐

Please list any recent hospitalizations/surgeries

____

____

____

Any other medical problems/concerns not already identified? YES ____ NO ____ (Please list below)

____

____

(FOR STAFF)

____

____

____

Have you ever had your cholesterol measured? YES ____ NO ____ (value) ______ (Date) ________

Are you taking any Prescription or Non-Prescription medications? YES ____ NO ____ (including birth control)

Medication Reason for taking medication For how long?

____
____
____
____
____
____

Do you currently smoke? YES ____ NO ____
How much per day: < .5 pack ___ 0.5 to 1 pack ___ 1.5-2 packs ___ > 2 packs ___

Have you ever quit smoking? YES ____ NO ____ When? ________ How many years did you smoke? ____

Do you drink any alcoholic beverages? YES ____ NO ____ If yes, how much in 1 week?
Beer _____(cans) Wine _____(glasses) Hard liquor _____(drinks)

Do you drink any caffeinated beverages? YES ____ NO ____ If yes, how much in 1 week?
Coffee _____(cups) Tea _____(glasses) Soft drinks _____(cans)

ACTIVITY LEVEL EVALUATION

What is your activity level at work? sedentary/retired _____ light _____ moderate _____ heavy _____

Do you currently engage in vigorous physical activity on a regular basis? YES ____ NO ____

If so, what type? ____ How many times per week? ________

How much time per day? (check one) < 15 min _____ 15-30 min _____ 30-45 min _____ > 60 min _____

Do you ever have an uncomfortable shortness of breath during exercise? YES ____ NO ____

Do you ever have chest discomfort during exercise? YES ____ NO ____ If so does it go away with rest? ____

Do you engage in any recreational or leisure-time activities on a regular basis? YES ____ NO ____

If so, what activities? ____

On average: How often? _______________ times/week For how long? _______________time/session

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Are you currently following a weight reduction diet plan? YES ____ NO ____
If so, how long have you been dieting? _____months Is the plan prescribed by your doctor? YES ____ NO ____

Have you used weight reduction diets in the past? YES ____ NO ____ If yes, how often and what type?

____

Please indicate the reason you want to start an exercise program.
To lose weight _____ Doctor's recommendation _____ For good health _____ Enjoyment _____

Release of tension _____ Improve physical appearance _____ Other ___________________________________

I have filled out this form to the best of my knowledge:

Signature:____ **Date:**___________________________