



Medical History Form

Name: _____ Sex: Male Female

Birth date: _____ Age: _____

Street Address: _____

City, State, Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Physician: _____ Physician's Phone: _____

Emergency Contact: _____ Phone: _____

Please answer the following questions as completely as possible. These questions will help to provide information on your present level of health and fitness, and will be used to develop an individualized exercise program for you.

Medical History

1. Has your doctor ever said you have heart trouble, high cholesterol or high blood pressure? If yes, please explain.

2. Circle any of the conditions that apply to your health history:

Diabetes	Asthma	Anemia	Arthritis
Heart Trouble	Cancer	Kidney Disease	Bursitis

High or Low Blood Pressure	Emphysema	Liver Disease	Recent illness or flu
Stroke	Lung Disease	Hip Pain	Tendonitis
Knee Pain	Thyroid Disease	Low Back Pain	Recent Surgery

Please explain any of the above conditions in detail:

Has your physician ever advised you that you have a bone or joint problem that can be made worse by exercise?

3. Have you ever experienced any of the following?

Heart or chest pain Shortness of breath Dizzy or faint spells

Please explain any of the above conditions in detail:

4. Please list any medications you are currently taking:

5. If you are a female, are you pregnant at this time? _____

Family History

Please circle any of the following that apply to your family history:

Coronary artery disease	Angina	High Blood Pressure
Diabetes	High Cholesterol	Sudden death
Heart attack before the age of 50	Heart attack after the age of 50	
Congenital Heart Disease		

Lifestyle Questionnaire

1. Do you currently perform vigorous exercise? If yes, please list the activities that you do:

2. If you are not currently involved in an exercise program, have you been in the past? If yes, please list past activities: _____

3. What are your fitness goals? _____

4. How many times per week are you willing to work with a fitness professional? _____
How many times per week are you willing to work out on your own? _____

5. What is your current occupation? _____
Does your occupation require extended periods of sitting? _____
Does your occupation require extended periods of repetitive movements? _____

6. Are you under any stress or depression?

7. Is there any other reason not mentioned above that might hinder your participation in an exercise program? _____

If there is any physical problem that would possibly impair your participation in an exercise program or put you at risk, be prepared to have a medical clearance form completed by your physician prior to starting your exercise program. All information is confidential and will not be released to any outside parties.

I certify that I have answered the above questions to the best of my knowledge. I understand that the information will be used to determine appropriate screening and testing before development of my exercise and fitness program.

Signature: _____ Date: _____