

Health History Form:

Name: _____ Date: _____

Age: _____

Sex: Male Female

Physicians Name: _____ Phone: _____

Emergency contact:

Name: _____ Phone: _____

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

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

| Do you now, or have you had in the past: | Yes | No |
|--|--------------------------|--------------------------|
| 1. History of heart problems (heart attack), chest pain or stroke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Bypass or cardiac surgery | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Pulmonary diseases or disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Chest discomfort with exertion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Increased blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Rapid or runaway heartbeat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Skipped heartbeat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Shortness of breath w/ or w/o exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Fainting or lightheadedness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Diabetes or thyroid condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Cigarette smoking habit? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. High blood fat (lipid) levels? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Any conditions or disease not mentioned here? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Recent hospitalization for any reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Hernia, or any condition that may be aggravated by lifting weights? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Orthopedic problems (including arthritis) | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Injuries that may affect your ability to exercise? | <input type="checkbox"/> | <input type="checkbox"/> |

For any of the above conditions checked above, please list the diagnosis and examining physician:
