



HEALTH HISTORY QUESTIONNAIRE

Name _____ Date: _____
 Address _____ Gender: M F Age _____
 Physician's Name _____
 Physician's Phone _____
 Person to contact in case of Emergency:
 Name _____ Phone _____
 Are you taking any medications or drugs? If so, please list medication, dose
 and reason. _____

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

Describe any physical activity you do somewhat regularly.

<i>Do you now, or have you in the past had any of the following?</i>	Yes	No
1. History of heart problems, chest pain or stroke	_____	_____
2. Increased blood pressure	_____	_____
3. Any chronic illness or condition	_____	_____
4. Difficulty with physical exercise	_____	_____
5. Advice from physician not to exercise	_____	_____
6. Recent surgery (last 12 months)	_____	_____
7. Pregnancy (now or within the last 3 months)	_____	_____
8. History of breathing or lung problems	_____	_____
9. Muscle, joint or back disorder, or any previous injury still affecting you	_____	_____
10. Diabetes or thyroid condition	_____	_____
11. Cigarette smoking habit	_____	_____
12. Obesity (more than 20 percent over ideal body weight)	_____	_____
13. Increased blood cholesterol	_____	_____
14. History of heart problems in immediate family	_____	_____
15. Hernia, or any condition that may be aggravated by lifting weights	_____	_____

Please explain any "yes" answers on the back and to your instructor.
 Please list any physical or medical restrictions: _____

I, hereby attest that the above personal health information is accurate and I also understand that I
 am participating in the exercise program under my own free will.

 Signature