

Health/Medical Questionnaire

Date: _____

Name: _____ Date of birth: _____ Soc. Sec. #: _____

Address: _____

Street City State Zip

Phone (H): _____ (W): _____ E-mail address: _____

In case of emergency, whom may we contact?

Name: _____ Relationship: _____

Phone (H): _____ (W): _____

Personal physician

Name: _____ Phone: _____ Fax: _____

Present/Past History

Have you had OR do you presently have any of the following conditions? (Check if yes.)

- Rheumatic fever
- Recent operation
- Edema (swelling of ankles)
- High blood pressure
- Injury to back or knees
- Low blood pressure
- Seizures
- Lung disease
- Heart attack
- Fainting or dizziness with or without physical exertion
- Diabetes
- High cholesterol
- Orthopnea (the need to sit up to breathe comfortably) or paroxysmal (sudden, unexpected attack) nocturnal dyspnea (shortness of breath at night)
- Shortness of breath at rest or with mild exertion
- Chest pains
- Palpitations or tachycardia (unusually strong or rapid heartbeat)
- Intermittent claudication (calf cramping)
- Pain, discomfort in the chest, neck, jaw, arms, or other areas with or without physical exertion
- Known heart murmur
- Unusual fatigue or shortness of breath with usual activities
- Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side, arm, or leg of your body
- Other

Family History

Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions? (Check if yes.) In addition, please identify at what age the condition occurred.

- Heart arrhythmia
- Heart attack
- Heart operation
- Congenital heart disease
- Premature death before age 50
- Significant disability secondary to a heart condition
- Marfan syndrome
- High blood pressure
- High cholesterol
- Diabetes
- Other major illness _____

Explain checked items: _____

Activity History

1. How were you referred to this program? (Please be specific.) _____

2. Why are you enrolling in this program? (Please be specific.) _____

3. Are you presently employed? Yes ___ No ___
4. What is your present occupational position? _____
5. Name of company: _____
6. Have you ever worked with a personal trainer before? Yes ___ No ___
7. Date of your last physical examination performed by a physician: _____
8. Do you participate in a regular exercise program at this time? Yes ___ No ___ If yes, briefly describe:

9. Can you currently walk 4 miles briskly without fatigue? Yes ___ No ___
10. Have you ever performed resistance training exercises in the past? Yes ___ No ___
11. Do you have injuries (bone or muscle disabilities) that may interfere with exercising? Yes ___ No ___ If yes, briefly describe: _____

12. Do you smoke? Yes ___ No ___ If yes, how much per day and what was your age when you started?
Amount per day _____ Age _____
13. What is your body weight now? _____ What was it one year ago? _____ At age 21? _____
14. Do you follow or have you recently followed any specific dietary intake plan, and in general how do you feel about your nutritional habits? _____

15. List the medications you are presently taking. _____

16. List in order your personal health and fitness objectives.
 - a. _____

 - b. _____

 - c. _____
