

Health History Questionnaire

Name:		Date:	
Home Address:			
Telephone: (H)		(W)	
Occupation:			
Age:	Gender:	Weight (lbs):	Height (in.):

Answer yes or no to the following questions:

(if details are required please use the details section at the bottom of the form)

	Yes	No
1. Have you ever been told that you have a heart condition?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had a heart attack?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been told you have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how high was it?		
4. Have you ever had a stroke?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever felt pain in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever felt pain in your chest when at rest?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been told that you have high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has an immediate family member (parent or sibling) had a heart attack, stroke or cardiovascular disease before 55 years of age?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever lost consciousness or lost your balance due to dizziness?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have emphysema?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have chronic bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what trimester are you in? - 1 2 3		

13. Do you currently smoke?

How many cigarettes per day?

14. Do you have diabetes?

15. Are you currently being treated for any bone, orthopedic, or joint problem that could be aggravated by physical activity?

16. Have you been treated for any bone, orthopedic, or joint problem in the past that could be aggravated with present physical activity?

If yes, how many years ago did this occur?

17. Are you currently taking medication that your doctor prescribed?

If yes please list each medication and why you are taking it in the following table:

Medication	Reason for taking it	Effect
1		
2		
3		
4		
5		
6		

Yes **No**

18. Are you currently physically active?

If yes, complete the table below stating how much (days/week & time spent)of each type of exercise you do:

	Sports	Stretching	Aerobics	Strength Training	
Days/Week					
Time Spent					
				Yes	No
19. Select the primary physical activities of your day:					
Sitting Lifting Loads Standing Driving Walking					
20. Is there any valid physical reason why you should not participate in an exercise/physical activity program?					
Details Section: (if required)					

Once this form is complete, please **print** and **sign**. The form should be returned to your trainer.

Signature: _____

Date: _____