

# HEALTH-HISTORY QUESTIONNAIRE



Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Sex M F

Physician's Name \_\_\_\_\_ Physician's Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Person to contact in case of emergency:

Name \_\_\_\_\_ Phone \_\_\_\_\_

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

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

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Describe any physical activity you do somewhat regularly.

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Do you now have, or have you had in the past:

	Yes	No
1. History of heart problems, chest pain, or stroke	<input type="checkbox"/>	<input type="checkbox"/>
2. Elevated blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
3. Any chronic illness or condition	<input type="checkbox"/>	<input type="checkbox"/>
4. Difficulty with physical exercise	<input type="checkbox"/>	<input type="checkbox"/>
5. Advice from physician not to exercise	<input type="checkbox"/>	<input type="checkbox"/>
6. Recent surgery (last 12 months)	<input type="checkbox"/>	<input type="checkbox"/>
7. Pregnancy (now or within last 3 months)	<input type="checkbox"/>	<input type="checkbox"/>
8. History of breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/>
9. Muscle, joint, or back disorder, or any previous injury still affecting you	<input type="checkbox"/>	<input type="checkbox"/>
10. Diabetes or metabolic syndrome	<input type="checkbox"/>	<input type="checkbox"/>
11. Thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>
12. Cigarette smoking habit	<input type="checkbox"/>	<input type="checkbox"/>
13. Obesity [body mass index (BMI) $\geq 30$ kg/m <sup>2</sup> ]	<input type="checkbox"/>	<input type="checkbox"/>
14. Elevated blood cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
15. History of heart problems in immediate family	<input type="checkbox"/>	<input type="checkbox"/>
16. Hernia, or any condition that may be aggravated by lifting weights or other physical activity	<input type="checkbox"/>	<input type="checkbox"/>

