



Health History Questionnaire

Basic Information

Name _____
 Date _____
 Age _____
 Height _____
 Weight _____
 Primary Physician's Name _____
 Primary Physician's Address _____
 Primary Physician's Phone _____

Health History

Please indicate your history related to each of the following conditions by checking the appropriate box. If you have had any condition in the past, please indicate the date in the appropriate space.

| Condition | Never | Now | Have Had (Date) |
|--|-------|-----|--------------------|
| Heart murmur, clicks, or other cardiac findings | | | |
| Frequent extra, skipped, or rapid heart beats/palpitations | | | |
| Heart attack, coronary bypass, or other cardiac surgery | | | |
| Chest pain/angina (especially upon exertion) | | | |
| Currently pregnant | | | |
| Diagnosed with high blood pressure | | | |
| Leg cramps during exercise | | | |
| Chronic swollen ankles | | | |
| Varicose veins | | | |
| Frequent dizziness/fainting | | | |
| Blood clot | | | |
| Severe arthritis | | | |
| Orthopedic problem(s) or complaint(s) | | | |
| Chronic back pain | | | |
| Musculoskeletal problems(s) or complaint(s) | | | |
| Asthma | | | |
| Cancer | | | |
| Diabetes | | | |
| Epilepsy | | | |
| Rheumatic Fever | | | |
| Scarlet Fever | | | |
| Bronchitis | | | |
| Stroke | | | |
| Pneumonia | | | |

Recent Surgery (Please describe and give dates.)

Other medical problems/considerations, recent illness(es), hospitalizations(s), or injury

Current medications/prescriptions

Do you smoke? _____

Date of last complete medical or physical exam: _____

Do you know of any medical or health conditions, considerations, or circumstances that might make it dangerous or unwise for you to participate in an exercise program?

Family Health History

Please indicate the number of blood relatives (mother, father, grandparents, brothers, sisters, children) who have had a heart attack prior to age 65 _____

have had a stroke _____

have had or now have diabetes _____

have been or are substantially overweight _____

The information submitted on this Health History Form is true and complete to the best of my knowledge, and I understand that any wrong or incomplete information could result in a less effective fitness program, injury, or illness.

Signature

Print Name