Health History Form

Name: ______________________________ Date: ______________

Age: __________ D.O.B. ____________

Phone: __________(Home) __________(Cell) __________(Work)

Address: ______________________________ Email: ______________

Street City Zip

Do you now, or have you had in the past	Yes	No
1. Any cardiovascular issues (stroke, blood pressure, etc.)	☐	☐
2. Any chronic illnesses or conditions	☐	☐
3. Diabetes, thyroid, renal, etc. conditions	☐	☐
4. Difficulty with physical exercise	☐	☐
5. Recent surgery (last 12 months)	☐	☐
6. Pregnancy (now or within the last 3 months)	☐	☐
7. History of breathing or lung problems	☐	☐
8. Cigarette smoking habit	☐	☐
9. Increased blood cholesterol	☐	☐
10. Increased blood sugar	☐	☐
11. Hernia or any condition that may be aggravated by lifting weights	☐	☐
12. Muscle, joint, or back disorder or any previous injury still affecting you: (Head, Neck, Shoulders, Elbows, Wrists, Fingers, Hips, Knees, Ankles, Toes)	☐	☐
13. Any bone disorders (recent breaks, osteoporosis, osteopenia)	☐	☐
14. Any other conditions that may affect your ability to exercise	☐	☐
15. Advice from physician not to exercise	☐	☐

Please explain any "yes" answers or any conditions which may be aggravated by a fitness program.

Comments ____

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If you are taking any medications please list medication, dose and reason:

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