

# HEALTH HISTORY QUESTIONNAIRE

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

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

Person to contact in case of emergency:

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

Do you have injuries (bone or muscle disabilities) that may interfere with exercising?.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there any specific area that is causing you discomfort or pain?

\_\_\_\_\_

Describe any physical activity you do somewhat regularly.

\_\_\_\_\_

\_\_\_\_\_

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

Yes No

1. History of heart problems, chest pain, or stroke

2. Elevated blood pressure

3. Any chronic illness or condition

4. Difficulty with physical exercise

5. Advice from physician not to exercise

6. Recent surgery (last 12 months)

7. Pregnancy (now or within last 3 months)

8. History of breathing or lung problems (i.e asthma)

9. Muscle, joint, or back disorder, or any previous injury still affecting you

- 10. Diabetes or metabolic syndrome
- 11. Hernia, or any condition that may be aggravated by lifting weights or other physical activity
- 12. Arthritis

13. List in order your personal health and fitness objectives.

a. \_\_\_\_\_

\_\_\_\_\_

b. \_\_\_\_\_

\_\_\_\_\_

c. \_\_\_\_\_

\_\_\_\_\_

14. Additional Comments:

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_