Health History Questionnaire

NAME: ___________________________ DATE: _____________________

Age: __________   Sex: Male / Female

Physician's Name:____

Physician's Phone:(_____)_______________________________________

Person to contact in case of Emergency:

Name: _______________________________ Phone: __________________

1. Are you taking any medications or drugs? YES NO

   If YES, please list medication, dose and reason:

   Medication:____
   Reason:____

   Medication:____
   Reason:____

   Use the back for more space

2. Does your physician know you are participating in an exercise program? Yes No
3. Describe any physical activity you do somewhat regularly:
   1.
   2.
   3.
   4.
   5.
4. Do you now, or have you had in the past:

	Yes		No
History of heart problems, chest pain or stroke			
Increased blood pressure			
Any chronic illness or condition			
Difficulty with physical exercise			
Advice from physician not to exercise			
Recent surgery (last 12 months)			
Pregnancy (now or within last 3 months)			

History of breathing or lung problems		
Muscle, joint or back disorder, or any previous injury still affecting you		
Diabetes or thyroid condition		
Cigarette smoking habit		
Obesity (more than 20 percent over ideal body weight)		
Increased blood cholesterol		
History of heart problems in immediate family		
Hernia, or any condition that may be aggravated by lifting weights		

5. Please explain any "yes" answers on the back.

Comments: