Health History Questionnaire

NAME: _____ DATE: _____
Birthdate: _____Gender: Male Female
Height:_____ Weight:_____ BMI_____

Person to contact in case of Emergency:
Name: _____ Phone: _____

1. Are you taking any medications or drugs?
   If YES, please list medication, dose and reason:
   Medication:_____Dose:_____Reason:_____
   Medication:_____Dose:_____Reason:_____
   Medication:_____Dose:_____Reason:_____
   Medication:_____Dose:_____Reason:_____
   Use the back for more space

YES	NO	
□	□	1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
□	□	2. Do you feel pain in your chest when you do physical activity?
□	□	3. In the past month, have you had chest pain when you weren't doing physical activity?
□	□	4. Do you lose your balance because of dizziness or do you ever lose consciousness?
□	□	5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
□	□	6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
□	□	7. Do you know of any other reason why you should not do physical activity?

General Health Questions:	Yes	No
History of heart problems, chest pain or stroke		
Increased blood pressure		
History of breathing or lung problems		
Diabetes or thyroid disease		
Seizures, tremors or severe headaches		
Arthritis or other bone problems		
Increased blood cholesterol		
Use products containing tobacco or nicotine regularly		
Recent surgery (last 12 months)		
Any other chronic illness or condition Please List:		