HEALTH HISTORY & FITNESS QUESTIONNAIRE

Name: ______________________________ Age: ________ DOB: ______________

Address: ____

Home Phone: ______________________ Cell: ______________________

Occupation: ____

Emergency contact: ______________________ Emergency Phone: ______________

Primary Care Physician: __________________ PCP Group Name: ______________

PCP Phone: ______________________

PERSONAL MEDICAL HISTORY

Have you ever been diagnosed with or do you suffer from the following:

___ Heart Attack	___ Stroke	___ High Cholesterol	___ Back Pain
___ Heart Disease	___ Diabetes	___ High Blood Pressure	___ Angina
___ Epilepsy	___ Asthma	___ Low Blood Pressure	___ Irregular Heartbeat/Murmur
___ Cancer	___ Varicose Veins	___ Arthritis	___ Shortness of Breath
___ Pulmonary Disease	___ Fainting	___ Joint Pain	___ Peripheral Vascular Disease

Have you had cardiac surgery? ____

Have you been hospitalized or had any surgery (including outpatient) in the past 3 years? ______________

Please describe: ____

____

Do you smoke?__________ Please list any side effects from medication(s) that might affect activity:

____

Do you currently exercise or participate in a sport?______________________________

If you answered yes, what do you do? ______________________________

____

Is there anything else we should know about your current health? ______________________

____

____

FITNESS

What are your fitness goals? ______________________________

____

What is your exercise history? ______________________________

____

______________________ ______________ ______________________

Your Signature | Date | Trainer's Name