



Health and Medical History Questionnaire

DATE: _____

Name _____ Age _____ DOB _____

Tel. (H) _____ Tel. (W) _____ Tel. (C) _____

Email _____

Physician's Name _____ Phone _____

Emergency Contact: Name _____ Phone _____

1. Do you smoke? Yes No

2. Has your doctor ever said your blood pressure was too high? Yes No

3. Do you have Diabetes or a thyroid condition? Yes No

4. Do you have any cardiovascular problems (heart disease, previous heart attack, atherosclerosis, abnormal electrocardiogram, chest pain)? Yes No

If yes, please describe: _____

5. Is there a history of heart problems in your immediate family? Yes No

If yes, please describe: _____

6. Do you have high blood cholesterol? Yes No

7. Are you overweight? Yes No

8. Do you have any injuries or orthopedic problems (muscle, joint, or back disorder; arthritis, tendinitis, etc.)? Yes No

If yes, please describe: _____

9. Do you have a history of breathing or lung problems (e.g. asthma) or shortness of breath? Yes No

If yes, please describe: _____

10. Do you have a Hernia, or any other condition that may be aggravated by lifting weights? Yes No

If yes, please describe: _____

11. Have you ever received advice from your physician not to exercise? Yes No

Health and Medical History Questionnaire (continued)

12. Have you had surgery within the last 12 months? Yes No

If yes, please describe: _____

13. Have you ever been hospitalized for any reason? Yes No

If yes, please describe: _____

14. Do you have any chronic illness or medical condition not previously mentioned? Yes No

If yes, please describe: _____

15. Are you taking any prescribed medications or dietary supplements? Yes No

If yes, please describe: _____

16. Are you pregnant or postpartum within the last three months? Yes No

17. Date of last physical exam: _____

18. Family medical history:

Father:

Alive Current age: _____

My father's general health is:

Excellent Good Fair Poor

Deceased Age at death: _____ Cause of death: _____

Mother:

Alive Current age: _____

My mother's general health is:

Excellent Good Fair Poor

Deceased Age at death: _____ Cause of death: _____

19. Does your physician know you are participating in this exercise program? Yes No

20. Describe any physical activity you do somewhat regularly: _____

21. Describe your eating habits: _____

22. Do you drink alcohol? Yes No

If yes, how much? _____