Health/Medical Questionnaire

Date: _____

Name: _____ Date of birth: _____ Soc. Sec. #: _____

Address: _____

Street City State Zip

Phone (H): _____ (W): _____ E-mail address: _____

In case of emergency, whom may we contact?

Name: _____ Relationship: _____

Phone (H): _____ (W): _____

Personal physician

Name: _____ Phone: _____ Fax: _____

Present/Past History

Have you had OR do you presently have any of the following conditions? (Check if *yes*.)

___ Rheumatic fever
___ Recent operation
___ Edema (swelling of ankles)
___ High blood pressure
___ Injury to back or knees
Low blood pressure
___ Seizures
___ Lung disease
___ Heart attack
___ Fainting or dizziness with or without physical exertion
___ Diabetes
___ High cholesterol
___ Orthopnea (the need to sit up to breathe comfortably) or paroxysmal (sudden, unexpected attack) nocturnal dyspnea (shortness of breath at night)
___ Shortness of breath at rest or with mild exertion
___ Chest pains
___ Palpitations or tachycardia (unusually strong or rapid heartbeat)
___ Intermittent claudication (calf cramping)
___ Pain, discomfort in the chest, neck, jaw, arms, or other areas with or without physical exertion
___ Known heart murmur
___ Unusual fatigue or shortness of breath with usual activities
___ Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side, arm, or leg of your body
___ Other

Family History

Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions? (Check if *yes*.) In addition, please identify at what age the condition occurred.

___ Heart arrhythmia
___ Heart attack
___ Heart operation
Congenital heart disease
___ Premature death before age 50
Significant disability secondary to a heart condition
___ Marfan syndrome
___ High blood pressure
___ High cholesterol
___ Diabetes
___ Other major illness _____

Health/Medical Questionnaire *(continued)*

Explain checked items:

Activity History

1. How were you referred to this program? (Please be specific.)

2. Why are you enrolling in this program? (Please be specific.)

3. Are you presently employed? Yes ___ No ___
4. What is your present occupational position? _____
5. Name of company: _____
6. Have you ever worked with a personal trainer before? Yes ___ No ___
7. Date of your last physical examination performed by a physician:
8. Do you participate in a regular exercise program at this time? Yes ___ No ___ If yes, briefly describe:

9. Can you currently walk 4 miles briskly without fatigue? Yes ___ No ___
10. Have you ever performed resistance training exercises in the past? Yes ___ No ___
11. Do you have injuries (bone or muscle disabilities) that may interfere with exercising? Yes ___ No ___ If yes, briefly describe:

12. Do you smoke? Yes ___ No ___ If yes, how much per day and what was your age when you started?
    Amount per day _____ Age _____
13. What is your body weight now? ____ What was it one year ago? ____ At age 21? ____
14. Do you follow or have you recently followed any specific dietary intake plan, and in general how do you feel about your nutritional habits?

15. List the medications you are presently taking.

16. List in order your personal health and fitness objectives.
    a.

    b.

    c.