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MEDICAL HISTORY QUESTIONNAIRE

Name _____Date ___/___/___

Home Address _____

Home Phone_____

Work Address_____

Work Phone _____

E-mail_____

Age _____ Date of Birth ____ / ____ / ____ Sex _____ Height _____ Weight _____

General Medical History:

CIRCLE ONE

1. Do you currently have any medical complaints? _____ Yes No Date
   _____
2. Have you ever been hospitalized, treated for serious illness, or had surgery? If yes, please explain. _____ Yes No _____
   _____
3. Have you had major surgery or an injury that might hinder or prohibit participation in an exercise program? If yes, please explain. Yes No _____
   _____
4. Are you currently under a physician's care for any physical health problem?_____ Yes No
   If yes, please explain: _____
5. Are you aware of any problems that would keep you from participating in regular, vigorous physical activity.
   Yes No
   If yes, explain: _____

6. Are you presently taking any medication (prescription and non-prescription)? Yes No

Medication	Dose	Reason for taking	For how long?

7. Do you have, have you recently experienced, or have you ever had (check those applicable):

- o rheumatic fever
- o high cholesterol
- o high blood pressure
- o infections
- o aneurysm
- o asthma
- o embolism
- o stroke
- o diabetes
- o edema/swelling
- o pneumonia
- o increased anxiety
- o emotional disorder
- o trouble sleeping
- o knee problems
- o lightheadedness, fainting or dizziness
- o respiratory discomfort
- o fixed rate pacemaker
- o emphysema
- o bronchitis
- o depression
- o low blood pressure
- o valve disease
- o rapid heart beats or irregular heart beats
- o disordered eating
- o migraine
- o back problems
- o foot problems
- o disease of arteries
- o abnormal lack of energy
- o arthritis
- o neck problems
- o hernia
- o bursitis
- o broken bones
- o heart attack
- o heart medications
- o stomach problems
- o limited movement in joints
- o shoulder problems
- o ulcers
- o anemia
- o heart murmur
- o thromgophlebitis
- o angina/chest pain/discomfort
- o epilepsy/seizure
- o shortness of breath

8. Do any of your immediate family/grandparents have a history of (check those applicable):

- o heart disease
- o heart surgery
- o high cholesterol
- o diabetes
- o heart attack
- o congenital heart disease
- o high blood pressure
- o stroke
- o premature death

If yes, please note relationship and age_____

Weight History (this will remain confidential between you and your trainer)

9. One year ago _____ Today _____ Maximum Ever _____

Smoking History Ever Yes No

10. How long since you quit? How many cigarettes/day? Now Yes No #_____

Nutrition History

11. Do you drink caffeinated coffee or colas? ___Yes ___No If yes, how many per week_____

12. Are you now or have you ever been on a diet? ___Yes ___No If yes, please explain:
_____

13. Do you consider yourself overweight? ___Yes ___No Do you consider yourself underweight? ___Yes ___No

14. Number of meals you usually eat per day:____

15. Do you usually eat breakfast? ___Yes ___No

****I have read, understood and completed this questionnaire. To the best of my knowledge, the above information is true. I understand that if my health changes in such a way as to limit my exercise capacity, I will tell my fitness professional.***

Signature: _____ Date:_____

****All information is kept confidential.****