

All information you provide is personal and confidential. The information will enable us to better understand you and your health and fitness habits as well as inform you of any potential risks. Please consult your physician before beginning any type of exercise program.

NAME \_\_\_\_\_ ID \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Address \_\_\_\_\_  
 City, State Zip \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ Email \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_  
 Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

**GENERAL**

Height \_\_\_\_\_ ft. Weight \_\_\_\_\_ lbs.

Any unexplained significant weight loss/gain . . . Within the last 6 months  Within the last year  NO   
 If yes, please explain:

\_\_\_\_\_

What was your most recent blood pressure reading? \_\_\_\_/\_\_\_\_ mm Hg Date \_\_\_\_\_

Do you currently exercise? YES  NO

If yes, how long have you been exercising regularly? \_\_\_\_\_

What exercise do you do and how often?

\_\_\_\_\_

**MEDICAL DIAGNOSES**

Have you ever had any of the following?

<b>Heart attack</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<b>Emboli – (Blood clot)</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>Angina</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<b>Coronary Artery Disease</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>Asthma</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<b>Stroke</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>Anemia</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<b>Cancer</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>Osteoporosis</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<b>Pulmonary Disease</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>Cardiovascular surgery</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<b>Heart Valve Problems</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>Currently pregnant</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<b>Rheumatic Fever</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>Emphysema</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<b>Phlebitis -</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>Allergies</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	(inflammation of a vein)		

Please list all known allergies:

\_\_\_\_\_

Any special conditions not listed above:

\_\_\_\_\_

**If you answered, “YES” to any of the above Medical Diagnoses,  
 It is RECOMMENDED that you consult with your physician before beginning your exercise program.**

**MEDICATIONS**

Please list any medications you are currently taking including but not limited to prescriptions, allergy medications, ergogenic aids, diet supplements, vitamins, minerals, etc.

Medication	Reason	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____

**MAJOR RISK FACTORS**

- 1. Are you a man over the age of 45 or a woman over the age of 55, Having had a hysterectomy, or are postmenopausal? YES  NO
- 2. Has your father or brother experienced a heart attack before age 55? Or has your mother or sister experienced a heart attack before the age of 65? Who? \_\_\_\_\_ YES  NO
- 3. Has your doctor ever told you that you might have high blood pressure? YES  NO
- 4. Do you have cholesterol above 200 ml/dl? Total cholesterol \_\_\_\_\_ HDL \_\_\_\_\_ Date tested \_\_\_\_\_ Unknown \_\_\_\_\_ YES  NO
- 5. Do you have impaired fasting glucose (diabetes)? If yes – Do you take insulin? YES  NO  What year were you diagnosed? \_\_\_\_\_ YES  NO
- 6. Are you physically inactive (i.e., you get less than 30 minutes of physical activity on at least 3 days per week) YES  NO
- 7. Do you currently smoke or have you quit smoking in the last 6 months? I smoke (#) \_\_\_\_\_ cigarettes per day/week (circle one) for \_\_\_\_\_ years. YES  NO  I smoked (#) \_\_\_\_\_ cigarettes per day/week (circle one) \_\_\_\_\_ years ago.
- 8. Are you > 20 pounds overweight? YES  NO

**If you are a man over the age of 45 or a woman over the age of 55  
OR if you answered “YES” to two (2) or more of the above Major Risk Factors,  
It is RECOMMENDED that you receive physician’s clearance before beginning your exercise program.**

**MAJOR SIGNS/SYMPTOMS  
SUGGESTIVE OF CARDIOVASCULAR AND PULMONARY DISEASE**

- 1. Pain discomfort (or anginal equivalent) in the chest, neck, jaw, arms, or other areas that may be due to ischemia (decreased blood flow) YES  NO
- 2. Shortness of breath at rest or w/mild exertion YES  NO
- 3. Dizziness or syncope at rest or w/mild exertion YES  NO
- 4. Orthopnea/paroxysmal nocturnal dyspnea (labored breathing) at rest or w/mild exertion YES  NO
- 5. Edema (excessive accumulation of tissue fluid) YES  NO
- 6. Palpitations or tachycardia (sudden rapid heart beat) YES  NO
- 7. Intermittent Claudication (lameness due to decreased blood flow) YES  NO
- 8. Known heart murmur (abnormal heart sound) YES  NO
- 9. Unusual fatigue or shortness of breath with usual activities YES  NO

**If you answered, “YES” to any of the above Major Signs and Symptoms listed above  
Or have known cardiovascular, pulmonary, or metabolic disease (see below for descriptions),  
It is STRONGLY RECOMMENDED that you seek physician’s clearance before beginning your exercise program.**

Cardiovascular – cardiac, peripheral vascular, cerebro-vascular disease  
Pulmonary – Chronic obstructive pulmonary disease, asthma, interstitial lung disease, or cystic fibrosis  
Metabolic Disease – Diabetes mellitus (types 1 and 2), thyroid disorders, renal or liver disease.

I understand this Health History Questionnaire has been provided to me for the purpose of helping me better understand any potential risks associated with a workout program. I also understand I should share this information with my physician and seek his or her approval prior to beginning an exercise program. I understand the information I have provided will be maintained in my membership file for use in case of a medical emergency. My signature signifies that all of the above is true, to the best of my knowledge. Any information left unanswered was done so intentionally. If any of the above information changes, I agree to submit these changes in writing to this facility’s wellness professional for an update to my membership file.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Received by: \_\_\_\_\_ Date: \_\_\_\_\_

I understand this Health History Questionnaire has been provided to me for the purpose of helping me better understand any potential risks associated with a workout program, to share with my physician in order to obtain his or her approval before beginning an exercise program, and to be maintained as part of my membership file in case of a medical emergency. **I do not want to complete this questionnaire and understand I assume full responsibility for any risks associated with my participation in an exercise program.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Received by: \_\_\_\_\_ Date: \_\_\_\_\_

Wellness Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Notes Attached: \_\_\_\_\_

**Note: All Major Risk Factors, Signs and Symptoms classifications are taken directly from Whaley, Mitchell H, ed. ACSM’s Guidelines for Exercise Testing and Prescription. Philadelphia, PA: Lippincott Williams & Wilkins, 2006.**