Health History Form

Date: _____

First Name:_____ Last Name:_____ Middle Name:_____

Address:_____City:_____

State:_____ Postal Code:_____

Primary Phone:_____ Cell Phone Number:_____

Date of Birth (MM/DD/YYYY):_____ Email Address:_____

Emergency Contact Name:_____ Emergency Contact Phone:_____

Relationship:_____

Physician's Name:_____ Physician's Phone:_____

Does your physician know you are participating in this program? ☐ Yes ☐ No

Describe your current exercise and diet program._____

_____

What medications are you on?_____

Check the boxes below that pertain to you either now or in the past:

- ☐ Advice from physician not to exercise
- ☐ Angina (chest pain treated with nitroglycerin)
- ☐ Angioplasty
- ☐ Arthritis
- ☐ Asthma/Breathing Issues
- ☐ Back Pain
- ☐ Blood in your stool
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Cerebral Palsy
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Diabetes
- ☐ Difficulty with physical exercise
- ☐ Dizziness
- ☐ Fibromyalgia
- ☐ Hepatitis B (serum) or C (from transfusion, not food)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ History of Smoking
- ☐ Intestinal Polyps
- ☐ Joint Pain
- ☐ Joint Replacement
- ☐ Menopausal (pre, post)
- ☐ Osteoporosis
- ☐ Overuse Injury
- ☐ Overweight
- ☐ Other digestive problems
- ☐ Pregnancy Now/Last 3 months
- ☐ Prescription Medications
- ☐ Stress
- ☐ Stroke
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Other:_____