Personal Health History

Date: _____ Staff: _____

Name: _____ Member #: _____ Gender: _____

Birth Date: _____ Phone (home): _____ Phone (work): _____

Emergency Contact: _____ Relation: _____ Phone: _____

What short and long term goals do you have concerning your health and fitness?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

What does your current exercise program consist of (how often, for how long, doing what)?

Activity	Times Per Week	Duration
1.		
2.		
3.		

Personal Health History

YES NO

☐ ☐ 1. Has a doctor ever restricted your physical activity?
If yes, why? _____

☐ ☐ 2. Do you have any chronic or serious illnesses that may affect your exercise (i.e. epilepsy, asthma)?
If yes, why? _____

☐ ☐ 3. Are you presently taking any medications that may affect your exercise?
Please list the type, purpose and dosage: _____

☐ ☐ 4. Have you been hospitalized in the last three years for any reason that may affect your exercise?
Please describe: _____

☐ ☐ 5. Do you have any allergies that may affect your exercise (i.e. cleaning solutions, vinyl, etc.)?
Please list: _____

☐ ☐ 6. Have you been pregnant in the last 3 years? _____

How much did you weigh 1 year ago? _____ 5 years ago? _____ At age 20? _____

Coronary Artery Disease (CAD) Risk factors (ACSM, 2000 GETP 6th edition)

Please check any that apply and indicate the age of onset:

		You	Mother	Father	Siblings
☐	Heart Disease				
☐	High Blood Pressure		N/a	N/a	N/a
☐	Diabetes		N/a	N/a	N/a
☐	By-Pass Surgery				
☐	High Cholesterol		N/a	N/a	N/a
☐	Stroke				

Do You Smoke? _____ How Much Do You Smoke? _____ Did You Smoke? _____ When Did You Quit? _____

Injuries

Please identify any significant injuries, surgeries, broken bones, muscle strains, ligament, tendon or cartilage damage to the following areas. Please also note any chronic or acute pain:

- ☐ Head & Neck _____
- ☐ Shoulders & Arms _____
- ☐ Back & Ribs _____
- ☐ Hips & Pelvis _____
- ☐ Abdomen _____
- ☐ Low Back _____
- ☐ Legs & Knees _____
- ☐ Ankles & Feet _____

Are you currently being treated for any of these injuries? If yes, please describe:

_____
_____
_____
_____
_____
_____

Lifestyle

YES NO

☐ ☐ Do you consider your diet to be well balanced?

☐ ☐ Do you feel that you have a lot of stress in your life?

Which of the following best describes you:

☐ I manage stress well ☐ I sometimes feel pressure/rushed ☐ I often feel pressured/rushed

YES NO

☐ ☐ Do you travel often?

☐ 1 – 3x/year ☐ 1-3x/month ☐ 1-3x/week ☐ Other _____

Compared to other males/females of your age, how would your rate your overall health?

☐ Poor ☐ Fair ☐ Good ☐ Excellent

What other information can you provide that might be helpful in designing a fitness program that is customized and personalized to suit your needs?

_____
_____
_____
_____
_____
_____