Health History Questionnaire

Name: Date:

Home Address: Email:

Telephone:(H) (W)

Occupation:

Age: Gender: Weight (lbs): Height (in.):

Answer yes or no to the following questions:
(if details are required please use the details section at the bottom of the form)

	Yes	No
1. Have you ever been told that you have a heart condition?	○	○
2. Have you ever had a heart attack?	○	○
3. Have you ever been told you have high blood pressure?	○	○
If yes, how high was it?		
4. Have you ever had a stroke?	○	○
5. Have you ever felt pain in your chest during exercise?	○	○
6. Have you ever felt pain in your chest when at rest?	○	○
7. Have you ever been told that you have high cholesterol?	○	○
8. Has an immediate family member (parent or sibling) had a heart attack, stroke or cardiovascular disease before 55 years of age?	○	○
9. Have you ever lost consciousness or lost your balance due to dizziness?	○	○
10. Do you have emphysema?	○	○
11. Do you have chronic bronchitis?	○	○
12. Are you pregnant?	○	○
If yes, what trimester are you in? - 1 ○ 2 ○ 3 ○		

13. Do you currently smoke?	○	○
How many cigarettes per day?		
14. Do you have diabetes?	○	○
15. Are you currently being treated for any bone, orthopedic, or joint problem that could be aggravated by physical activity?	○	○
16. Have you been treated for any bone, orthopedic, or joint problem in the past that could be aggravated with present physical activity?	○	○
If yes, how many years ago did this occur?		
17. Are you currently taking medication that your doctor prescribed?	○	○

If yes please list each medication and why you are taking it in the following table:

Medication	Reason for taking it	Effect
1		
2		
3		
4		
5		
6		

	Yes	No
18. Are you currently physically active?	○	○

If yes, complete the table below stating how much (days/week & time spent)of each type of exercise you do:

	Sports	Stretching	Aerobics	Strength Training
Days/Week				
Time Spent				

	Yes	No
19. Select the primary physical activities of your day:		
Sitting ☐ Lifting Loads ☐ Standing ☐ Driving ☐ Walking ☐		
20. Is there any valid physical reason why you should not participate in an exercise/physical activity program?	○	○

Details Section: (if required)

Once this form is complete, please **print** and **sign**. The form should be returned to your trainer.

Signature: _____

Date: _____