Health History

Name_____Date_____

Address_____ City_____

State_____ Zip code_____ Age_____ Sex M___ F ____

Emergency contact_____ Phone_____

Are you taking any medications, supplements, or drugs? If so please list them and the reason for taking.

_____

_____

Does your physician know you are participating in this exercise program?

_____

Describe any physical activity you do regularly.

_____

_____

Do you now, or have you had in the past:	YES	NO
1. History of heart problems, chest pain, or stroke	___	___
2. Elevated blood pressure	___	___
3. Any chronic illness or condition	___	___
4. Difficulty with physical exercise	___	___
5. Advise from physician not to exercise	___	___
6. Recent surgery (last 12 months)	___	___
7. Pregnancy now or within the last 3 months	___	___
8. History of breathing or lung problems	___	___
9. Muscle, joint, or back disorder, or any previous injury still Affecting you	___	___
10. Diabetes or thyroid condition	___	___
11. Cigarette smoking habit	___	___
12. Obesity	___	___
13. Elevated blood cholesterol	___	___
14. History of heart problems in immediate family	___	___
15. Hernia, or any condition that may be aggravated by lifting Weights or other physical activity	___	___