Health & Exercise History Form

Name____ Date___________

Age___________ Sex___________ Height_________ Weight________

Emergency Contact Info:
Name_______________________________ Phone_______________
Relationship__________________

Are you taking any medications/drugs? If yes, please list medication, dose, and reason.
____
____
____

Describe any physical activity you do somewhat regularly.
____
____
____

Do you now, or have you had in the past: (please circle any that apply)

1. History of heart problems, chest pain, or stroke
2. Increased blood pressure
3. Any chronic illness or condition
4. Difficulty with physical exercise
5. Advice from physician not to exercise
6. Recent surgery (last 12 months)
7. Pregnancy (now or within last 3 months)
8. History of breathing or lung problems
9. Muscle, joint, or back disorder, or previous injury
10. Diabetes or thyroid condition
11. Cigarette smoking habit
12. Obesity (more than 20% over ideal body weight)
13. Increased blood cholesterol
14. History of heart problems in immediate family
15. Hernia, or any condition that may be aggravated by lifting weights

Please explain any "yes" answers.
____
____
____
____

Rate yourself on a scale of 1 to 5 (lowest to highest). Circle the number that best applies.

Characterize your present athletic ability.
1 2 3 4 5

Characterize your present muscular capacity.
1 2 3 4 5

Characterize your present cardiovascular capacity.
1 2 3 4 5

Characterize your present flexibility capacity.
1 2 3 4 5

Are you currently involved in regular exercise?
Strength training________ _______ minutes/day _______ days/week
Cardio________________ _______ minutes/day _______ days/week

Rate your perception of exertion of your current exercise program.
(1) Light (2) Fairly light (3) Somewhat hard (4) Hard

How long have you been exercising regularly?
_______ Months _______Years

What other exercise, sport, recreational activities have you participated in during the past 6 months?____