

Health History Questionnaire

www.Zegee.com/trainer/paul1970mc

I. Personal Information:

first name: _____ last name: _____ birthdate: _____
height: _____ weight: _____
phone (cell / home / work): _____
highest education: (high school / college / graduate) occupation: _____
name of physician: _____ phone: _____

II. Additional Information:

Have you exercised within the past 6 months? Yes No
Have you previously participated in any fitness program? Yes No
Are you currently dieting? Yes No
Cigarettes smoked per week: _____
Alcoholic drinks consumed per week: _____
Cups of coffee or tea consumed per week: _____
Cans of soda drinks consumed per week: _____

III. Health History Part 1: (Indicate any diseases or illnesses you have had or currently have:)

<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergies	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Back Condition	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Joint Pain
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Hernia	<input type="checkbox"/> Nervous Tension	<input type="checkbox"/> Sinus
<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV	<input type="checkbox"/> Other

IV. Health History Part 2: (Do you have or have you ever had:)

Have you ever been hospitalized	Yes	No
Heart Attack or Heart Trouble	Yes	No
Chest Pain or Angina Pectoris	Yes	No
Coronary Bypass or Angioplasty	Yes	No
Abnormal Exercise Stress Test	Yes	No
Heart Murmur (suggesting a heart abnormality)	Yes	No
Irregular Heart Beat or Rhythm (suggesting a heart abnormality)	Yes	No
High Blood Pressure Above 145/95	Yes	No
Impaired Circulation	Yes	No
Stroke	Yes	No
Convulsions or Loss of Consciousness	Yes	No
Diabetes Mellitus	Yes	No
High Blood Cholesterol Level	Yes	No
If female - are you pregnant	Yes	No
Do you smoke or have you ever used smokeless tobacco for a total of 10 years	Yes	No

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IV. Health History Part 2: (continued from the previous page)

Musculoskeletal Limitations of Movement	Yes	No
Difficulty Breathing / Shortness of Breath	Yes	No
Arthritis, Rheumatism	Yes	No
Knee Problems	Yes	No
Hip Problems	Yes	No
Shoulder Problems	Yes	No
Feet Problems	Yes	No
A chronic, recurrent or morning cough	Yes	No
Any episode of coughing up blood	Yes	No
Increased anxiety or depression	Yes	No
Swollen, stiff or painful joints	Yes	No
Back Pain (Herniated or ruptured Disc)	Yes	No
Surgery	Yes	No
Increased anxiety or depression	Yes	No

IMPORTANT: If you answered Yes to any of the previous questions, contact your physician as soon as possible.

Cholesterol Profile: HDLs _____ LDLs _____ Total _____

Blood Pressure: Systolic _____ Diastolic _____

Are you taking any medication? Yes No

Specify Type & Dosage: _____

When was your last physical examination? _____

I certify to the best of my knowledge the above information is correct and complete. I also understand that Paul McAlavey assumes no responsibility for any illness, accident or injury I may incur from the use of the programs, services or facilities. All individuals are strongly encouraged to consult with a physician before entering a non-medically supervised exercise program.

Client Signature: _____

Date: _____

Trainer Signature: _____

Date: _____