Health History

Participant
Name:____
Address:____
Local Phone:____
Email:____
Birthdate:__________ Height:_________Age:______ Gender:______
OCCUPATION:____

Primary Health Care Provider
Doctor:_______________________________ Phone:____________
Address:____

1. Do you Smoke?______ How often?____

2. Do you use alcohol?______ How often?_______________________________________

3. Do you have high or low blood pressure? Y or N What were the last 3 readings?
___/___; ___/___; ___/___

4. Do have any cardiovascular problems or disease? Y or N,
Explain:_______________________
____
____
____

5. Have you experienced chest pain when doing physical activity? Yes or No

6. Do you loose consciousness or loose balance because of dizziness? Yes or No

7. Are you pregnant or post-partum? Yes or No

8. Do you have diabetes? Y or N,
Explain____
____
____

9. Have you had surgery within the last 2 years?
What?__________________________________

10. Are you taking any medications (prescribed or not)? Please
List.______________________
____
____

Adapted from Brooks, D. S. (1997).

11. Are you taking any supplements or vitamins? Please List?____________________________

____
____

12. When were you last seen by a physician?____

13. Do you have any injuries or orthopedic problems (bursitis, bad back, bad knees, etc.) ______

____
____
____

14. Have you been told you have high cholesterol levels?_______________________________

15. Please check all conditions that you have or have had in the past.

- o Heart attack
- o Diabetes
- o Stroke
- o Chest discomfort
- o Heart murmur
- o Trouble sleeping
- o Migraine or headache
- o Neck problems
- o Back problems
- o Broken Bones
- o Shortness of breath
- o Anemia
- o Asthma
- o Epilepsy
- o Anxiety or depression
- o Fatigue
- o Hernia
- o Stomach problems
- o Limited range of motion
- o Arthritis
- o Swelling of joints

Adapted from Brooks, D. S. (1997).

Please, explain any conditions that you checked (i.e. treatment, symptoms, restrictions)________

____
____
____
____
____
____

16. Have you in the past or currently had/have any other medical conditions or problems not previously mentioned? Explain?

____
____
____
____
____
____
____

Consent Form

I acknowledge that I am in good health, have answered the previous questions truthfully, and have no known medical problems that would preclude safe participation in this exercise program.

Signed:____Date:_____________

Adapted from Brooks, D. S. (1997).