



MEDICAL HEALTH HISTORY

New member: YES NO

All information you provide is personal and confidential. The information will enable us to better understand you and your health and fitness habits as well as inform you of any potential risks. Please consult your physician before beginning any type of exercise program.

NAME _____ ID _____ DATE ____/____/____
 Address _____
 City, State Zip _____
 Employer _____
 Phone (H) _____ (W) _____ Email _____
 Date of Birth ____/____/____ Male _____ Female _____
 Emergency Contact _____ Phone _____ Relation _____
 Physician's Name _____ Phone _____ Fax _____

GENERAL

Height _____ ft. Weight _____ lbs.

Any unexplained significant weight loss/gain . . . Within the last 6 months Within the last year NO
 If yes, please explain:

What was your most recent blood pressure reading? ____/____ mm Hg Date _____

Do you currently exercise? YES NO

If yes, how long have you been exercising regularly? _____

What exercise do you do and how often?

MEDICAL DIAGNOSES

Have you ever had any of the following?

Heart attack	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Emboli – (Blood clot)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Angina	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Coronary Artery Disease	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Asthma	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Stroke	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Anemia	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Cancer	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Osteoporosis	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Pulmonary Disease	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Cardiovascular surgery	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Heart Valve Problems	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Currently pregnant	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Rheumatic Fever	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Emphysema	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Phlebitis -	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Allergies	YES <input type="checkbox"/>	NO <input type="checkbox"/>	(inflammation of a vein)		

Please list all known allergies: _____

Any special conditions not listed above: _____

**If you answered, "YES" to any of the above Medical Diagnoses,
 It is RECOMMENDED that you consult with your physician before beginning your exercise program.**

MEDICATIONS

Please list any medications you are currently taking including but not limited to prescriptions, allergy medications, ergogenic aids, diet supplements, vitamins, minerals, etc.

Medication	Reason	Dosage

MAJOR RISK FACTORS

- 1. Are you a man over the age of 45 or a woman over the age of 55, Having had a hysterectomy, or are postmenopausal? YES NO
- 2. Has your father or brother experienced a heart attack before age 55? Or has your mother or sister experienced a heart attack before the age of 65? Who? _____ YES NO
- 3. Has your doctor ever told you that you might have high blood pressure? YES NO
- 4. Do you have cholesterol above 200 ml/dl? Total cholesterol _____ HDL _____ Date tested _____ Unknown _____ YES NO
- 5. Do you have impaired fasting glucose (diabetes)? If yes – Do you take insulin? YES NO What year were you diagnosed? _____ YES NO
- 6. Are you physically inactive (i.e., you get less than 30 minutes of physical activity on at least 3 days per week) YES NO
- 7. Do you currently smoke or have you quit smoking in the last 6 months? I smoke (#) _____ cigarettes per day/week (circle one) for _____ years. YES NO I smoked (#) _____ cigarettes per day/week (circle one) _____ years ago.
- 8. Are you > 20 pounds overweight? YES NO

**If you are a man over the age of 45 or a woman over the age of 55
OR if you answered “YES” to two (2) or more of the above Major Risk Factors,
It is RECOMMENDED that you receive physician’s clearance before beginning your exercise program.**

**MAJOR SIGNS/SYMPTOMS
SUGGESTIVE OF CARDIOVASCULAR AND PULMONARY DISEASE**

- 1. Pain discomfort (or anginal equivalent) in the chest, neck, jaw, arms, or other areas that may be due to ischemia (decreased blood flow) YES NO
- 2. Shortness of breath at rest or w/mild exertion YES NO
- 3. Dizziness or syncope at rest or w/mild exertion YES NO
- 4. Orthopnea/paroxysmal nocturnal dyspnea (labored breathing) at rest or w/mild exertion YES NO
- 5. Edema (excessive accumulation of tissue fluid) YES NO
- 6. Palpitations or tachycardia (sudden rapid heart beat) YES NO
- 7. Intermittent Claudication (lameness due to decreased blood flow) YES NO
- 8. Known heart murmur (abnormal heart sound) YES NO
- 9. Unusual fatigue or shortness of breath with usual activities YES NO

**If you answered, “YES” to any of the above Major Signs and Symptoms listed above
Or have known cardiovascular, pulmonary, or metabolic disease (see below for descriptions),
It is STRONGLY RECOMMENDED that you seek physician’s clearance before beginning your exercise program.**

Cardiovascular – cardiac, peripheral vascular, cerebro-vascular disease
Pulmonary – Chronic obstructive pulmonary disease, asthma, interstitial lung disease, or cystic fibrosis
Metabolic Disease – Diabetes mellitus (types 1 and 2), thyroid disorders, renal or liver disease.

I understand this Health History Questionnaire has been provided to me for the purpose of helping me better understand any potential risks associated with a workout program. I also understand I should share this information with my physician and seek his or her approval prior to beginning an exercise program. I understand the information I have provided will be maintained in my membership file for use in case of a medical emergency. My signature signifies that all of the above is true, to the best of my knowledge. Any information left unanswered was done so intentionally. If any of the above information changes, I agree to submit these changes in writing to this facility’s wellness professional for an update to my membership file.

Signature: _____ Date: _____ Received by: _____ Date: _____

I understand this Health History Questionnaire has been provided to me for the purpose of helping me better understand any potential risks associated with a workout program, to share with my physician in order to obtain his or her approval before beginning an exercise program, and to be maintained as part of my membership file in case of a medical emergency. **I do not want to complete this questionnaire and understand I assume full responsibility for any risks associated with my participation in an exercise program.**

Signature: _____ Date: _____ Received by: _____ Date: _____

Wellness Representative Signature: _____ Date: _____ Notes Attached: _____

Note: All Major Risk Factors, Signs and Symptoms classifications are taken directly from Whaley, Mitchell H, ed. ACSM’s Guidelines for Exercise Testing and Prescription. Philadelphia, PA: Lippincott Williams & Wilkins, 2006.