

Y Not Personalized Fitness

Personal Data

Name: _____ Date: _____

Address: _____ D.O.B.: _____

Email: _____ Sex: M F

Phone # (H) _____ Fax #: _____
 (O) _____
 (C) _____

Person to Contact in Case of Emergency: _____
 Name: _____ Physicians Name: _____
 Relationship: _____ Physicians #: _____
 Phone #: _____

Health History Questionnaire

Are you currently taking medications?

Med Name	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does your physician know your participating in this exercise program? _____
 Describe your current exercise program, if applicable. _____

Do you now have, or have you had in the past:	YES	NO
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 a physician, not to exercise	_____	_____
6. Recent Surgery (Past 12 months)	_____	_____
7. Pregnancy (Now or in past 3 months)	_____	_____
8. History of breathing or lunge problems	_____	_____
9. Muscle, Joint or Back disorder	_____	_____
10. Previous injury still affecting you	_____	_____
11. Diabetes or thyroid condition	_____	_____
12. Increased blood cholesterol	_____	_____
13. History of heart problem in your immediate family	_____	_____
14. Hernia, or condition possibly aggravated by lifting weights	_____	_____
15. Cigarette smoking habit	_____	_____

(Please note any comments & concerns on the reverse side of this page)