

HEALTH-HISTORY QUESTIONNAIRE

Name _____ Date _____

Age _____ Sex ☐ M ☐ F

Physician's Name _____ Physician's Phone (_____) _____

Person to contact in case of emergency:

Name _____ Phone _____

Are you taking any medications, supplements, or drugs? If so, please list medication, dose, and reason.

Does your physician know you are participating in this exercise program?

Describe any physical activity you do somewhat regularly.

Do you now have, or have you had in the past:

	Yes	No
1. History of heart problems, chest pain, or stroke	<input type="checkbox"/>	<input type="checkbox"/>
2. Elevated blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
3. Any chronic illness or condition	<input type="checkbox"/>	<input type="checkbox"/>
4. Difficulty with physical exercise	<input type="checkbox"/>	<input type="checkbox"/>
5. Advice from physician not to exercise	<input type="checkbox"/>	<input type="checkbox"/>
6. Recent surgery (last 12 months)	<input type="checkbox"/>	<input type="checkbox"/>
7. Pregnancy (now or within last 3 months)	<input type="checkbox"/>	<input type="checkbox"/>
8. History of breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/>
9. Muscle, joint, or back disorder, or any previous injury still affecting you	<input type="checkbox"/>	<input type="checkbox"/>
10. Diabetes or metabolic syndrome	<input type="checkbox"/>	<input type="checkbox"/>
11. Thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>
12. Cigarette smoking habit	<input type="checkbox"/>	<input type="checkbox"/>
13. Obesity [body mass index (BMI) ≥ 30 kg/m ²]	<input type="checkbox"/>	<input type="checkbox"/>
14. Elevated blood cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
15. History of heart problems in immediate family	<input type="checkbox"/>	<input type="checkbox"/>
16. Hernia, or any condition that may be aggravated by lifting weights or other physical activity	<input type="checkbox"/>	<input type="checkbox"/>