

Health History Form

Name: _____ Membership Type _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: Day: _____ Evenings: _____ Mobile: _____

Gender: ___ M ___ F Date of birth: _____ Age: _____

Personal Physician: _____

Telephone: _____

Person to notify in case of an emergency: _____

Relationship: _____

Telephone: _____

MEDICAL HISTORY

Please check if you have had, or presently have, any of the following conditions and include month and year of your initial diagnosis:

Heart/vascular:

- Chest pain/angina _____
- Heart palpitations/extra or skipped beats _____
- Blackouts/fainting spells/ dizziness _____
- Swollen ankles _____
- Peripheral vascular disease/leg cramps/cold hands or feet _____
- Heart attack/heart valve disease _____
- Coronary by-pass/cardiac surgery _____
- Pacemaker _____
- Heart murmur _____
- Abnormal electrocardiogram _____
- High blood pressure _____
- High cholesterol _____
- Phlebitis _____
- Stroke _____
- Stents _____
- TIA _____
- Varicose veins _____
- Other _____

Respiratory:

- Asthma/exercise-induced asthma _____
- Emphysema _____
- Chronic bronchitis _____
- Breathing difficulty/shortness of breath _____

Joint/muscle:

- Arthritis/joint problems _____
- Disc problems _____
- Fractures _____
- Muscle pain/cramps/weakness _____
- Orthopedic problems _____
- Joint replacement _____
- Osteoporosis _____
- Other _____

Auto immune disease:

- Chronic Fatigue Syndrome _____
- Fibromyalgia _____
- AIDS/HIV _____
- Lupus _____
- Other _____

Neurologic:

- Multiple Sclerosis _____
- Alzheimer's Disease _____
- Parkinson's Disease _____
- Other _____

Women Only:

- Currently pregnant _____
- Lactating _____
- Menopausal _____
- Post-menopause _____
- Other _____

Metabolic disease:

- Diabetes, insulin dependent _____
- Diabetes, non insulin dependent _____
- Thyroid problems _____
- Other metabolic _____

Other:

- Paralysis _____
- Allergies _____
- Anemia _____
- Bleeding problems _____
- Cancer _____
- Epilepsy/seizures/convulsions _____
- Hernia _____
- Kidney or urinary tract disease _____
- Major surgery or hospitalization _____

- Mental health _____
- Overweight _____
- Rheumatic fever _____
- Stomach or bowel problems _____
- Chronic pain _____
- Eating disorders _____

(more on reverse)

MEDICAL HISTORY (continued)

Do you have any other physical limitations or medical conditions which should be considered before you begin an exercise program? Yes No

If yes, please explain: _____

Date of last physical exam: _____

Have you had an electrocardiogram (ECG): Resting Yes No Exercise (treadmill) Yes No

Please list any prescription medications, self-prescribed medications, dietary or herbal supplements:

FAMILY HISTORY

Please check if any of your immediate family members (parents, grandparents, or siblings) have any of the following:

Heart disease	Relationship _____	Age of onset _____
Diabetes	Relationship _____	Age of onset _____
Osteoporosis	Relationship _____	Age of onset _____
High blood pressure	Relationship _____	Age of onset _____
High cholesterol	Relationship _____	Age of onset _____
Cancer	Relationship _____	Age of onset _____

LIFESTYLE HISTORY

Smoking history: (including cigarettes, pipes and cigars):	Weight history:	Height History:
Non-smoker _____	Current weight _____ lbs.	Highest adult height _____
Ex-smoker _____ packs/day _____ years	Weight 6 months ago _____ lbs.	Current height _____
Current smoker _____ packs/day _____ years	Highest adult weight _____ lbs.	
	Lowest adult weight _____ lbs.	

Would you like us to send a copy of your physical assessment and testing to your physician: Yes _____ No _____

Physician: _____

Address: _____

City, State, Zip: _____

Phone: _____

<u>Trial Membership</u>
Start Date: _____
Appt: _____
Time: _____
Trainer: _____
Date Converted: _____



15000 Minnetonka Boulevard • Minnetonka, Minnesota 55345
Phone 952-935-2202 • Fax 952-935-9685

<u>Full Membership</u>
With Dr.: <input type="checkbox"/> Yes <input type="checkbox"/> No
Appt Date: _____
Time: _____
With: _____

Name _____

PHYSICAL/ACTIVITY HISTORY

Do you have a regular exercise routine? Yes No

If yes, please list (walking, biking, strength training, etc...):

Activity: _____ times/week: _____ duration: _____

Activity: _____ times/week: _____ duration: _____

Activity: _____ times/week: _____ duration: _____

Do you have any other sports, hobbies or recreational interest? (example: team sports, tennis, golf, gardening etc.)

Health/Fitness Interests

What activities are of interest to you?

- | | | |
|--|--|---|
| <input type="checkbox"/> Group fitness | <input type="checkbox"/> Pilates | <input type="checkbox"/> Rowing |
| <input type="checkbox"/> Water | <input type="checkbox"/> Biking | <input type="checkbox"/> Stairmaster |
| <input type="checkbox"/> Land | <input type="checkbox"/> Stationary Biking | <input type="checkbox"/> Spa services |
| <input type="checkbox"/> Lap swimming | <input type="checkbox"/> Outdoor | <input type="checkbox"/> Meditation |
| <input type="checkbox"/> Stretching/relaxation | <input type="checkbox"/> Strength | <input type="checkbox"/> Yoga |
| <input type="checkbox"/> Walking/jogging/running | <input type="checkbox"/> Personal training | <input type="checkbox"/> Golf |
| <input type="checkbox"/> Balance & Stability | <input type="checkbox"/> Tai Chi/Qi Gong | <input type="checkbox"/> Other activities |

What are your health goals:

- | | | | | |
|--|---|---|--|--|
| <input type="checkbox"/> Stress Management | <input type="checkbox"/> Postural improvement | <input type="checkbox"/> Social interaction | <input type="checkbox"/> Flexibility | <input type="checkbox"/> Endurance/Stamina |
| <input type="checkbox"/> Weight | <input type="checkbox"/> Nutrition | <input type="checkbox"/> Strength | <input type="checkbox"/> Balance & Stability | |

Other: _____

Is there any other information regarding your health/fitness goals you would like us to know? _____

Goal 1: _____

Goal 2: _____

Goal 3: _____

