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):
Non-smoker ___
Ex-smoker ___ packs/day ___ years
Current smoker ___ packs/day ___ years

Weight history:
Current weight _________ lbs.
Weight 6 months ago _________ lbs.
Highest adult weight _________ lbs.
Lowest adult weight _________ lbs.

Height History:
Highest adult height _______
Current height _______

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: ____

Trial Membership
Start Date: _______________
Appt: __________________
Time: __________________
Trainer: ________________
Date Converted: __________

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Full Membership
With Dr.: ❒ Yes ❒ 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/per week: ________ duration: _____

Activity: ________________ times/per week: ________ duration: _____

Activity: ________________ times/per 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?

❐Group fitness
- ❐Water
- ❐Land

❐Lap swimming
❐Stretching/relaxation
❐Walking/jogging/running
❐Balance & Stability

❐Pilates
❐Biking
- ❐Stationary Biking
- ❐Outdoor

❐Strength
❐Personal training
❐Tai Chi/Qi Gong

❐Rowing
❐Stairmaster
❐Spa services
❐Meditation
❐Yoga
❐Golf
❐Other activities

What are your health goals:

❐Stress Management ❐Postural improvement ❐Social interaction ❐Flexibility ❐Endurance/Stamina
❐Weight ❐Nutrition ❐Strength ❐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: ____

____

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