

# Health History Form

Name: \_\_\_\_\_ Membership Type \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email \_\_\_\_\_

Gender: \_\_\_\_\_ 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 \_\_\_\_\_



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.)

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### Health/Fitness Interests

What activities are of interest to you?

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

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? \_\_\_\_\_

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Goal 1: \_\_\_\_\_

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Goal 2: \_\_\_\_\_

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Goal 3: \_\_\_\_\_

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