

HEALTH HISTORY FORM

Name _____ Date _____

Age _____ Sex ____ M ____ F

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

Does your physician know you are participating in this exercise program? ____ Yes ____ No

Describe any physical activity you do somewhat regularly.

Do you now, or have you had in the past:	Yes	No
1. A history of heart problems, chest pains, or strokes	___	___
2. Increased blood pressure	___	___
3. Any chronic illness or condition	___	___
4. Difficulty with physical exercise	___	___
5. Advice from a physician not to exercise	___	___
6. Any recent surgery (last 12 months)	___	___
7. Pregnancy (now or within last 3 months)	___	___
8. A history of breathing or lung problems	___	___
9. Muscle, joint or back disorder, or any previous injury still affecting you	___	___
10. A diabetes or thyroid condition	___	___
11. A cigarette smoking habit	___	___
12. Obesity (more than 20 percent over ideal body weight)	___	___
13. Increased blood cholesterol	___	___
14. A history of heart problems in immediate family	___	___
15. Hernia, or any condition that may be aggravated by lifting weights	___	___

Comments:

(If you have any explanations for any answers that you think are noteworthy or other conditions that you think may be aggravated or may cause you to have problems performing any exercise or weightlifting activity, please explain those here. If you run out of room, you may use the back.)
