

FITNESS SOURCE
Health History Questionnaire

Name: _____ **Employer:** _____

Home Address: _____ **City:** _____ **ST:** _____ **Zip:** _____

Home Phone: (____) _____ **Work Phone** (____) _____

Gender: Male or Female **Birth Date:** ____ / ____ / ____

Doctors Name: _____ **Doctors Phone:** _____

Doctors Address: _____ **Doctors Fax:** _____

Regular physical activity is safe for most people. However, some individuals should check with their doctor before they start an exercise program. To help us determine if you should consult with your doctor before starting an exercise program at Fitness Source, please read carefully and honestly answer the following questions. All information will be kept confidential by Fitness Source staff.

Please circle YES or NO.

- YES NO 1. Do you have a heart condition?
YES NO 2. Have you ever experienced a stroke?
YES NO 3. Do you currently smoke?
YES NO 4. Has a physician ever told you or are you aware that you have high blood pressure?
YES NO 5. Has a physician ever told you or are you aware that you have high cholesterol?
YES NO 6. Has anyone in your immediate family (parents, brothers, sisters) had a heart attack, stroke or cardiovascular disease before the age of 55?
YES NO 7. Do you have diabetes?
YES NO 8. Do you consider yourself obese?
YES NO 9. Do you consider yourself to have an inactive lifestyle?
(PR if 2 or more of above)
YES NO 10. Do you have epilepsy?
YES NO 11. Do you have emphysema?
YES NO 12. Do you have arthritis?
YES NO 13. Do you feel pain in your chest when you engage in physical activity?
YES NO 14. Do you feel pain in your chest when you are NOT engaged in physical activity?
YES NO 15. Have you ever had unusual shortness of breath at rest or with mild exertion?
YES NO 16. Do you ever suffer from dizziness or fainting spells?
YES NO 17. Are you a male over 44 years of age?
YES NO 18. Are you a female over 54 years of age?
(PR if 1 or more of above)
YES NO 19. Are you currently taking medications?
Please list meds and purpose: _____

YES NO 20. Women Only: Are you pregnant? (PR)

Height _____ Weight _____ Age _____

Is there anything else regarding your health history that we should be aware of before you begin an exercise program? _____

TURN OVER

What are your health and fitness goals? Check all that apply:

- | | | |
|--|---|--|
| <input type="checkbox"/> Achieve balance in life | <input type="checkbox"/> Control blood pressure | <input type="checkbox"/> Control cholesterol |
| <input type="checkbox"/> Exercise regularly | <input type="checkbox"/> Feel better overall | <input type="checkbox"/> Improve cardiovascular fitness |
| <input type="checkbox"/> Improve flexibility | <input type="checkbox"/> Improve muscle tone | <input type="checkbox"/> Improve nutritional habits |
| <input type="checkbox"/> Improve productivity | <input type="checkbox"/> Increase muscle mass | <input type="checkbox"/> Increase Strength and endurance |
| <input type="checkbox"/> Injury rehab | <input type="checkbox"/> Other | <input type="checkbox"/> Reduce body fat |
| <input type="checkbox"/> Reduce stress | <input type="checkbox"/> Reduce back pain | <input type="checkbox"/> Stop smoking |

To the best of my knowledge I have completed this form honestly and completely. I understand it is my responsibility to inform the Fitness Source staff of any changes in my health status that may affect my participation in exercise activities.

Participant Signature

Date

Staff Use Only:

Cleared to Exercise Not cleared to Exercise Reason: _____

Number of Risk Factors Questions 1 – 9: _____

Number of Signs / Symptoms Questions 10 – 18,20: _____

Age: _____ Pregnant: YES or NO Physicians Release Requested: YES or NO Date Sent: _____ / _____ / _____

Staff Signature: _____