



## Health History Questionnaire

Please answer the following questions to the best of your ability. For the following questions, unless otherwise indicated, circle the single best choice for each question. As is customary, all of your responses are completely confidential and may only be used in group summaries and/or reports. All information collected is subject to the Privacy Act of 1974.

Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

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

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

Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

1. Have you ever had a definite or suspected heart attack or stroke? . . . . . Yes No
2. Have you ever had coronary bypass surgery or any other type of heart surgery? . . . . . Yes No
3. Do you have any other cardiovascular or pulmonary (lung) disease  
(other than asthma, allergies, or mitral valve prolapse)? . . . . . Yes No
4. Do you have a history of: diabetes, thyroid, kidney, liver disease? . . . . . Yes No  
(circle all that apply)
5. Have you ever been told by a health professional that you have had  
an abnormal resting or exercise (treadmill) electrocardiogram (EKG) . . . . . Yes No
6. If you answered YES to any of Questions 1 through 5, please describe:

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7. Do you currently have any of the following:
- a. pain or discomfort in the chest or surrounding areas that occurs when you engage in physical activity? . . . . . Yes No
  - b. shortness of breath . . . . . Yes No
  - c. unexplained dizziness or fainting . . . . . Yes No
  - d. difficulty breathing at night except in upright position . . . . . Yes No
  - e. swelling of the ankles (recurrent and unrelated to injury) . . . . . Yes No
  - f. heart palpitations (irregularity or racing of the heart on more than one occasion). . . . . Yes No
  - g. pain in the legs that causes you to stop walking (claudication). . . . . Yes No
  - h. known heart murmur . . . . . Yes No

Have you discussed any of the above with your personal physician? . . . . . Yes No

8. Are you pregnant or is it likely that you could be pregnant at this time? . . . . . Yes No  
 If yes, what is your expected due date? \_\_\_\_\_

9. Have you had surgery or been diagnosed with any disease in the past 3 months? . . . . . Yes No  
 If yes, please list date \_\_\_\_\_ and surgery/disease \_\_\_\_\_

10. Have you had high blood cholesterol or abnormal lipids within the past 12 months or are you taking medication to control your lipids? . . . . . Yes No

11. Do you currently smoke cigarettes or have quit within the past 6 months? . . . . . Yes No

12. Have your father or brother(s) had heart disease prior to age 55 OR mother or sister(s) had heart disease prior to age 65? . . . . . Yes No

13. Within the past 12 months, has a health professional told you that you have high blood pressure (systolic > 140 OR diastolic > 90)? . . . . . Yes No

14. Currently, do you have high blood pressure or within th past 12 months, have you taken any medicines to control your blood pressure? . . . . . Yes No

15. Have you ever been told by a health professional that you have a fasting blood glucose greater than or equal to 110 mg/dl? . . . . . Yes No

16. Describe your regular physical activity or exercise program:

type: \_\_\_\_\_

frequency: \_\_\_\_\_ days per week

duration: \_\_\_\_\_ minutes

intensity (circle one): low moderate high

BMI: \_\_\_\_\_

17. If you have answered YES to any of questions 7-16, please describe:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

18. Are you currently under any treatment for any blood clots? . . . . . Yes No
19. Do you have problems with bones, joints, or muscles that may be aggravated with exercise? . . . . . Yes No
20. Do you have any back/neck problems? . . . . . Yes No
21. Have you been told by a health professional that you should not exercise? . . . . . Yes No
22. Are you currently being treated for any other medical condition by a physician? . . . . . Yes No
23. Are there any other conditions (mitral valve prolapse, epilepsy, history of rheumatic fever, asthma, cancer, anemia, hepatitis, etc.) that may hinder your ability to exercise? . . . . . Yes No
24. During the past six months, have you experienced any unexplained weight loss or gain (greater than ten pounds for no known reason)? . . . . . Yes No
25. If you have answered YES to any of questions 18-24, please describe:

26. Please list below all prescription and over-the-counter medications you are currently taking:

Medicine:	Reason for taking:	Dosage:	Amount/Frequency:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

27. Are there any medicines that your physician has prescribed to you in the past 12 months which you are currently not taking? . . . . . Yes No
- If so, please list:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I have answered the *Health History Questionnaire* questions accurately and completely. I understand that my medical history is a very important factor in the development of my fitness/wellness program. I understand that certain medical or physical conditions which are known to me, but that I do not disclose to my trainer, may result in serious injury to me. If any of the above conditions change, I will immediately inform my trainer of those changes. I, knowingly and willingly, assume all risks of injury resulting from my failure to disclose accurate, complete and updated information in accordance with the attached questionnaire. I also understand that in order to properly risk stratify my Health History Questionnaire, my trainer should have a minimum of a national certification as a personal trainer. My trainer also verbally explained this statement to me to my understanding.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Trainer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_