



HEALTH HISTORY

Please check all that apply:

Cardiovascular Risks	Signs / Symptoms	Orthopedic / Other	Lifestyle & Dietary Factors
<input type="checkbox"/> Heart Disease <input type="checkbox"/> Pulmonary Disease <input type="checkbox"/> Metabolic Disease <input type="checkbox"/> Fam. History CHD <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Smoking <input type="checkbox"/> Sedentary Lifestyle	<input type="checkbox"/> Age <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Irregular/Accelerated Heart Rate	<input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis/Joint Pain <input type="checkbox"/> Back Spine Disorder <input type="checkbox"/> Musculoskeletal Pain <input type="checkbox"/> /Injury <input type="checkbox"/> Hernia <input type="checkbox"/> Surgery <input type="checkbox"/> Other _____	<input type="checkbox"/> Hypoglycemia <input type="checkbox"/> G.I. Disorder <input type="checkbox"/> High Triglycerides <input type="checkbox"/> Cancer <input type="checkbox"/> Pre/Postnatal <input type="checkbox"/> Anemia <input type="checkbox"/> Food Allergy <input type="checkbox"/> Other _____

Has your Doctor stated that you have a heart condition and that you should only do physical activity recommended by a Doctor? YES NO

Do you feel pain in your chest when you do physical activity? YES NO

In the past month, have you had chest pain when you were not doing physical activity? YES NO

Do you lose your balance because of dizziness, or do you ever lose consciousness? YES NO

Do you have a bone or joint problem that could be made worse by a change in your physical activity?
 YES NO

Is your doctor currently prescribing drugs for your blood pressure or heart condition? YES NO

Do you know of any other reason why you should not participate in physical activity? YES NO

	Type 1	Type 2	Type 3	Type 4
Medications				
Date Prescribed				

Please use the back of the page if needed.

Contacts	Daytime #	Evening #
Emergency Contact:		
Doctors Name:		
Date of last physical:		

The information above is true, accurate, and reflects my current physical condition

Name _____ Member Signature _____ Date: _____