PERSONAL HEALTH HISTORY FORM

NAME: _____ **DATE:** _____

SEX: _____ **AGE:** _____ **PHONE:** _____

ADDRESS: _____

_____

What is the present state of your general health? _____

_____

Does your physician know you are planning to participate in an exercise program? _____

Physician's name: _____ **Physician's phone#:**_____

Are you presently taking any medications? Please list? _____

_____

Emergency contact: _____ **Phone#:**_____

Do you now or have you had within the past year:	**YES**	**NO**
1. History of heart problems?	_____	_____
2. High blood pressure?	_____	_____
3. Difficulty with physical exercise?	_____	_____
4. A chronic illness?	_____	_____
5. Advice from a physician not to exercise?	_____	_____
6. Muscle, joint, or back disorder that could be aggravated by physical activity?	_____	_____
7. Recent surgery (within the past two months)?	_____	_____
8. History of lung problems?	_____	_____
9. History of diabetes?	_____	_____
10. Cigarette-smoking habit?	_____	_____
11. Obesity (more than 20 pounds overweight)?	_____	_____
12. High blood cholesterol?	_____	_____
13. History of heart problems in immediate family?	_____	_____

What regular physical activity do you presently do? _____

_____

To the best of my knowledge, all of the above information is correct.

Participant signature: _____ **Date:** _____