



GENERAL INFORMATION:

DATE COMPLETED: _____

First Name: _____ Last Name: _____

Date of Birth: ____/____/____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____)-____-____ Work Phone: (____)-____-____

Mobile Phone: (____)-____-____ E-mail Address: _____

Occupation: _____ Employer: _____

Employer Address: _____



Have you completed a physical in the past year? Yes No Month: ____ Year: ____

Family Physician: _____ Physician Phone: _____

In case of emergency, please contact: _____

Contact Phone #: (____)-____-____ Relationship to you: _____

Do you work out now: Yes No If yes, at the Gym or Home? _____

- Do you consider yourself:
- Sedentary (little, if any, vigorous activity)
 - Lightly Active (sporadic workout, little aerobic, lawn work)
 - Moderately Active (workout 1-2 days/wk for 15-30 min.)
 - Highly Active (workout 3+ days/wk for 30-45 min.)

Check All That Apply:

- Over the age of 16
- Exercise at least 10 hours/week - consistently for at least 6 months
- Have a resting heart rate of 60 beats per minute or less
- Have been very fit for years, but currently exercise less than 10 hours/week

What activities do you prefer in an exercise program? _____

What is the most you have ever weighed? _____

Do you frequently participate in competitive sports? Yes No

If yes, what sports? _____

What high school or college athletics did you participate in? _____



Do you smoke? Yes No

Have you ever smoked? Yes No

How many? _____

When did you quit? _____

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Hospitalization:

Have you ever been hospitalized with any illness or injury? Yes No

If yes, please explain:

Year: Reason:

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Orthopedic:

Have you ever had any bone, joint, muscular, back injuries, or conditions?

Yes No If yes, please explain: _____

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Family History:

Do any of your immediate family members (grandparents, parents or siblings) have, or have had, any of the following?

	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<u>Who</u>	<u>Age</u>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sudden Death	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Other _____

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Current Medications:

<u>Name of Medication</u>	<u>Dose</u>	<u>How Often</u>	<u>Reason</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to any medications? Yes No If so, which one(s): _____



Personal History:

Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Disease of an Artery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angioplasty	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Phlebitis/Emboli	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chronic Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest Pain/Discomfort at rest	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chest Pain w/ exertion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swelling of the feet/ankles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Skipped or rapid heart beats	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis/Swollen, stiff joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dizzy Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emotional Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Recent Illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If female, are you Pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please Explain _____			If yes, how far along? _____	Months	

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High Blood Pressure:

Have you ever been told you have high blood pressure? Yes No

If yes, what was the treatment you received? _____

Are you still being treated for high blood pressure? Yes No

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Pertinent Information:

Is there any pertinent information regarding your health history that has not already been described? Yes No

If yes, please explain: _____

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What are your Fitness Goals?
