Individual Health History Form

Date _____

Name _____ Birth Date _____

Sex: ☐ Male ☐ Female Height _____ Weight _____

Person to contact in case of emergency:

Name _____ Relation _____ Phone _____

Physicians Name _____ Phone _____

Date of Last Medical Exam _____

Does your physician know that you are participating in this exercise program? _____

Are you taking any medications or drugs? If so, please list medication and reason.

_____

_____

Do you now or have you had in the past:	Yes	No
1. History of heart problems, chest pain or stroke?	☐	☐
2. High blood pressure?	☐	☐
3. Any chronic illness or condition?	☐	☐
4. Difficulty with physical exercise?	☐	☐
5. Advice from physician not to exercise?	☐	☐
6. Recent surgery (last 12 months)?	☐	☐
7. Pregnancy (now or within the last 3 months)?	☐	☐
8. History of breathing or lung problems?	☐	☐
9. Muscle, joint or back disorder, or any previous injury still affecting you?	☐	☐
10. Diabetes or thyroid condition?	☐	☐
11. Cigarette smoking habit?	☐	☐
12. High blood cholesterol?	☐	☐
13. History of heart problems in immediate family?	☐	☐
14. Hernia or a condition that may be aggravated by physical exercise?	☐	☐
15. Fainting of dizzy spells?	☐	☐

Please explain any "yes" answers to the previous questions:

_____

_____

Describe any physical activity that you do regularly:

_____

_____

What goals to you hope to achieve?

_____

_____

How many days per week to you plan to exercise? _____

I understand that I must be in good health to participate in this program. I understand that Colonial Fitness Center, Flying Hills Fitness Center and Wyomissing Health Club, and their exercise instructors, are not able to provide me with medical advice with regard to my medical fitness, and that the information is used as a guideline to the limitations of my ability to exercise. I will not hold these Fitness Center responsible for any injury sustained during this program.

Member Signature _____ Date _____

Trainer Signature _____ Date _____