

Health History Form

NAME _____ DATE _____

AGE _____ SEX M F

TELEPHONE NUMBER _____ E-MAIL _____

PHYSICIAN'S NAME _____

PHYSICIAN'S PHONE _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

NAME _____ PHONE _____

Do you now, or have you had in the past:

- | | | |
|---|---|---|
| 1. Heart problems, chest pain, or stroke | Y | N |
| 2. Increased blood pressure | Y | N |
| 3. Any chronic illness or condition | Y | N |
| 4. Difficulty with physical exercise | Y | N |
| 5. Advice from physician not to exercise | Y | N |
| 6. Recent surgery (last 12 months) | Y | N |
| 7. Pregnancy (now or in last three months)
if so, require release from physician | Y | N |
| 8. History of breathing or lung problems | Y | N |
| 9. Muscle, joint, or back disorder, or any previous injury still
affecting you | Y | N |
| 10. Diabetes or thyroid condition | Y | N |
| 11. Cigarette smoking habit | Y | N |
| 12. History of heart problems in immediate family | Y | N |
| 13. Do you know of any other reason why you should not
exercise? | Y | N |

Please explain any "yes" answers.

COMMENTS:

Any and all information given is confidential and will not be used other than for the purpose of health and safety by Jennifer Janda.

PARTICIPANTS NAME (WRITTEN)

PARTICIPANTS SIGNATURE

DATE _____

