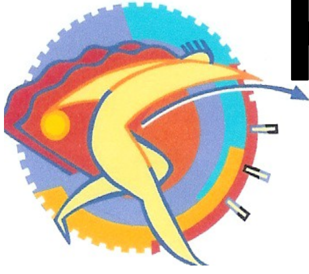

Health History Questionnaire

Name: ______________________________ Date: __________

Birthday: ______________________________ Sex: F M

Address: ______________________________ Age: __________

______________________________ Zip ____________

Phone: ______________________________ Email: ________________________

Physician's Name: ________________________

Physician's Ph #: ________________________

Date of last Physical ________________________

The following information is required to assess your physical fitness level and to establish your exercise prescription. Your health questionnaire and test results are confidential and will not be released to anyone other than yourself.

Have you ever experienced any of the following while walking, working or exercising?

Pain in the chest	Y________________________	N
Pain in the neck	Y________________________	N
Pain in the lower back	Y________________________	N
Abnormal shortness of breath	Y________________________	N
Faintness/Light headed	Y________________________	N
Confusion/Dizziness	Y________________________	N
Leg pain	Y________________________	N
Heart beat irregularities	Y________________________	N
Persistent cough	Y________________________	N

To your knowledge do you have or have you had any of the following?			**Is there a Family History**
Diabetes	Y____________________	N	Y
Heart/Cardiopulmonary disease -heart murmur, angina, heart attack, coronary, athleroscleroses	Y____________________	N	Y
Pulmonary disease -asthma, emphysema, bronchitis	Y____________________	N	Y
Gout (elevated uric acid)	Y____________________	N	Y
Thyroid, Kidney or Liver disease	Y____________________	N	Y
Stroke	Y____________________	N	Y
Rheumatic Fever	Y____________________	N	
Anemia-low red blood cell count	Y____________________	N	
Hernia	Y____________________	N	
Varicose Veins	Y____________________	N	
AIDS or HIV Positive	Y____________________	N	

Lisa Garrity Fitness Enterprises
619-917-1340
LGFitnessEnterprises@cox.net

Have you recently experienced any of the following:

Localized muscle soreness Y____ N
Joint stiffness Y____ N
Flare-up of old injuries Y____ N
Loss of local muscle strength Y____ N
Noticeable loss of muscle size Y____ N
Restricted joint movement Y____ N

Has your personal physician indicated that you have:

High Blood Pressure Y N

-If yes, please indicate Systolic ______________ Diastolic______________

Elevated Blood Cholesterol Y N

-If yes, please indicate level____________________________

Family history of either of the above?____

Do you take any medication on a regular basis? If yes, please list

Prescription	Non-Prescription	Supplements/Vitamins
_____________________	_____________________	_____________________
_____________________	_____________________	_____________________
_____________________	_____________________	_____________________
_____________________	_____________________	_____________________

Please list any past surgery, injury, pregnancy or serious illnesses and the date each occurred.

____________________ _______________________ _____________________

____________________ _______________________ _____________________

Do you smoke a pipe, cigars or cigarettes? Y N

per day_____________ # of years______________

If you have smoked, how long since you quit?_______________

Do you consume alcoholic beverages? Y N

If yes, Daily________ Weekly_________Monthly___________

Is there anything else related to your health or lifestyle that would affect your ability to participate in an exercise program?

____

____

If you have any questions about the information on this form or need assistance completing the information please contact Lisa Garrity — 619-209-2800 x 4