**Health/Medical Questionnaire**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

Phone (H): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, whom may we contact?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (H): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Present/Past History Have you had OR do you presently have any of the following conditions?**

**(Check if yes.)**

\_\_\_ Rheumatic fever

\_\_\_ Recent operation

\_\_\_ Edema (swelling of ankles)

\_\_\_ High blood pressure

\_\_\_ Injury to back or knees

\_\_\_ Low blood pressure

\_\_\_ Seizures

\_\_\_ Lung disease

\_\_\_ Heart attack

\_\_\_ Fainting or dizziness with or without physical exertion

\_\_\_ Diabetes

\_\_\_ High cholesterol

\_\_\_ Orthopnea (the need to sit up to breathe comfortably) or paroxysmal (sudden, unexpected attack) nocturnal dyspnea (shortness of breath at night)

\_\_\_ Shortness of breath at rest or with mild exertion

\_\_\_ Chest pains

\_\_\_ Palpitations or tachycardia (unusually strong or rapid heartbeat)

\_\_\_ Intermittent claudication (calf cramping)

\_\_\_ Pain, discomfort in the chest, neck, jaw, arms, or other areas with or without physical exertion

\_\_\_Known heart murmur

\_\_\_ Unusual fatigue or shortness of breath with usual activities

\_\_\_ Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side, arm, or leg of your body

\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions?**

**(Check if yes.) In addition, please identify at what age the condition occurred.**

\_\_\_ Heart arrhythmia

\_\_\_ Heart attack

\_\_\_ Heart operation

\_\_\_ Congenital heart disease

\_\_\_ Premature death before age 50

\_\_\_ Significant disability secondary to a heart condition

\_\_\_ Marfan syndrome

\_\_\_ High blood pressure

\_\_\_ High cholesterol

\_\_\_ Diabetes

\_\_\_ Other major illness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explain checked items:

 **Activity History**

1. How were you referred to this program? (Please be specific.)
2. Why are you enrolling in this program? (Please be specific.)
3. Are you presently employed? Yes \_\_\_ No \_\_\_
4. What is your present occupational position?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Name of company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Have you ever worked with a personal trainer before? Yes \_\_\_ No \_\_\_
7. Date of your last physical examination performed by a physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Do you participate in a regular exercise program at this time? Yes \_\_\_ No \_\_\_ If yes, briefly describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Can you currently walk 4 miles briskly without fatigue? Yes \_\_\_ No \_\_\_
10. Have you ever performed resistance training exercises in the past? Yes \_\_\_ No \_\_\_
11. Do you have injuries (bone or muscle disabilities) that may interfere with exercising?

Yes \_\_\_ No \_\_\_ If yes, briefly describe:

1. Do you smoke? Yes \_\_\_ No \_\_\_ If yes, how much per day and what was your age when you started? Amount per day \_\_\_\_\_\_ Age \_\_\_\_\_\_
2. What is your body weight now? \_\_\_\_ What was it one year ago? \_\_\_\_ At age 21? \_\_\_\_
3. Do you follow or have you recently followed any specific dietary intake plan, and in general how do you feel about your nutritional habits?
4. List the medications you are presently taking.

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| Name | Dose | Reason |
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1. List, in order, your personal health and fitness objectives.

*From NSCA, 2012, NSCA’s essentials of personal training, 2nd ed., J. Coburn and M. Malek (eds.), (Champaign, IL: Human Kinetics)*