EVOLVE
BODY • MIND • FITNESS

HEALTH-HISTORY QUESTIONNAIRE

NAME _____ *DATE* _____

D.O.B. ___ *AGE* ___ *HEIGHT* ___ *WEIGHT* ___ *SEX M / F*

ADDRESS _____

CITY _____ *STATE* _____ *ZIPCODE* ____

PHYSICIAN'S NAME _____ *PHYSICIAN'S PHONE* (____) _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

NAME _____

PHONE _____

ARE YOU TAKING ANY MEDICATIONS, SUPPLEMENTS, OR DRUGS? IF SO, PLEASE LIST MEDICATION, DOSE, AND REASON. _____

_____

_____

DOES YOUR PHYSICIAN KNOW YOU ARE PARTICIPATING IN THIS EXERCISE PROGRAM? _____

_____

DESCRIBE ANY PHYSICAL ACTIVITY YOU DO SOMEWHAT REGULARLY. _____

_____

_____

DO YOU NOW HAVE, OR HAVE YOU HAD IN THE PAST:

1. HISTORY OF HEART PROBLEMS, CHEST PAIN, OR STROKE
2. ELEVATED 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 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 METABOLIC SYNDROME
11. THYROID CONDITION
12. CIGARETTE SMOKING HABIT
13. OBESITY [BODY MASS INDEX (BMI) ≥30 KG/M2] 14. ELEVATED BLOOD CHOLESTEROL
15. HISTORY OF HEART PROBLEMS IN IMMEDIATE FAMILY
16. HERNIA, OR ANY CONDITION THAT MAY BE AGGRAVATED BY LIFTING WEIGHTS OR OTHER PHYSICAL ACTIVITY