

Health History Information

Name:			
Address:	City:	State:	Zip:
Home Phone #:	Alternate Phone #:		
e-mail address:			
Date of Birth:	Age:	Height:	Male / Female
Emergency Contact Name:		Phone #:	
Primary Physician:			

Indicate if you are currently or have previously experienced any situation below:

	Heart problems?
	History of heart problems in immediate blood-related family?
	Decreased or elevated blood pressure?
	Elevated blood cholesterol?
	Seizures or epilepsy?
	Hernia?
	Nervous system problems?
	Arthritis?
	Joint or hip problems?
	Asthma or other respiratory disorder?
	Circulatory problems?
	Cigarette smoking habit?
	Obesity (more than 20% over ideal body weight range)?
	Advice from a physician NOT to exercise or limit/reduce exercise?
	Any condition that may be aggravated by exercise?
	History of an eating disorder?
	Pregnancy now or in the past 3 months?
	Surgery in the past 12 months?

Do you have any medical conditions or health problems that may prevent or limit your exercise or impact your safety or health at any time that were not specifically asked? YES NO