

Fitness For Your Lifestyle, LLC

Client Health History Questionnaire

Name _____

Date _____

DOB _____

Street address _____

City/State/Zip _____

Home Phone _____

Work Phone _____

Gender (circle one) M F

Emergency Contact and Phone

How did you hear about me? _____

Please answer all the following questions to the best of your ability and knowledge.

Has a physician ever told you that you have heart trouble? Y ___ N ___

Do you frequently have pains in your heart and chest area? Y ___ N ___

Do you often feel faint or have spells of severe dizziness? Y ___ N ___

Has a physician ever told you that your high blood pressure was too high? Y ___ N ___

Has a physician ever told you that you have a bone or joint problem such as arthritis that has been aggravated or might be made worse by exercise? Y ___ N ___

Do you have a good physical reason not mentioned here why you should not follow an activity program even if you wanted to? Y ___ N ___

Are you over the age of 65 and not accustomed to vigorous exercises? Y ___ N ___

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Section 1

Have you ever had any of the following?

- Heart attack or heart failure? Y ___ N ___
- Heart Surgery Y ___ N ___
- Metabolic diseases? Y ___ N ___
- A pacemaker or other heart device? Y ___ N ___
- A heart valve or congenital heart disease? Y ___ N ___
- Pulmonary disease? Y ___ N ___
- A Stroke Y ___ N ___
- Coronary Artery Disease? Y ___ N ___
- If you are a woman, are you pregnant? Y ___ N ___
- Musculoskeletal or nerve problems? Y ___ N ___

Section 2

Have you ever experienced any of the following?

- Pain in your chest, neck or jaw? Y ___ N ___
- Shortness of breath with mild exertion? Y ___ N ___
- Palpitations, tachycardia, or irregular heart beat? Y ___ N ___
- Ankle swelling? Y ___ N ___
- Heart murmur? Y ___ N ___
- Dizziness? Y ___ N ___

Section 3

Indicate if you have had any of the following or if any apply to you:

- You are a male older than 45 years of age. Y ___ N ___
- You are woman over 55 years of age or have had a hysterectomy or are postmenopausal. Y ___ N ___
- You smoke or have quit smoking in the last 6 months. Y ___ N ___
- You have blood pressure greater than 140/90. Y ___ N ___
- You are physically inactive or get less than 30 minutes of physical activity on at least 3 day per week. Y ___ N ___
- You have total cholesterol greater than 200 mg/dL. Y ___ N ___
- You have a close male blood relative who had a heart attack before age 55 or a close female relative who had a heart attack before age 65. Y ___ N ___
- You have diabetes or take medication to control blood sugar. Y ___ N ___
- Take prescription medication. Y ___ N ___

If Yes to the above question, list your medications:

- You are more than 20 pounds overweight. Y ___ N ___

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I understand that exercise programs can create physical stress and possible harmful effect. I agree it is entirely my responsibility to consult with a physician prior to my initiating an exercise program. I also understand that exercise equipment can cause injury and take full responsibility for my actions or accidental injury and will use the facilities with care and caution.

Signature

Date

Staff use

Clear to Exercise

Not Cleared to Exercise. If not, why? _____

Staff Signature _____ Date _____