

MEDICAL QUESTIONNAIRE



Health, Fitness & Wellness Solutions

Today's Date _____

Occupation _____

Name _____ Age _____ Birth date _____

Address _____

City _____ State _____ Zip Code _____

Day Phone _____ Evening Phone _____ Email _____

Emergency Contact _____ Phone _____

Primary Health Care Provider _____

Physicians Name _____ Phone _____

Health History:

1. Do you smoke? _____ How often? _____

2. Has your doctor ever said your blood pressure was too high or low? _____ What was it? _____

3. Have you (or a family member) ever been told that you have diabetes? _____

4. Do you have any known cardiovascular problems (abnormal ECG, previous heart attack, atherosclerosis, etc.)? _____

5. Has your doctor ever told you your cholesterol level was high? _____ What was it? _____

6. Are you overweight? _____ How much? _____ According to? _____

7. Do you have any injuries or orthopedic problems (bursitis, bad back, bad knees, etc.)? _____

8. Are you taking any prescribed medications or dietary supplements? _____

9. Are you pregnant or post-partum less than six weeks? _____

10. Date of last physical examination. _____

11. Do you have any other medical conditions or problems not previously mentioned? _____

12. Are you currently involved in a regular exercise program? _____

13. Have you ever had professional assistance with your exercise? _____

14. What are your goals within this program? _____

Participant Consent

I acknowledge, to the best of my ability, that I am in good health and have no known medical conditions that would restrict my ability to participate in this exercise program.

Signature _____ Date _____

