Office Use Only:
Dr. Clearance Given? Y N
Membership # _____

Today's Date: _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____

Sex: _____ Age: _____ Birth Date: _____/_____/_____

Home Phone: _____ Work Phone: _____

Height: _____Ft. _____ In. Weight: _____

Physician's Name/Address: _____

Physician's Phone Number: _____ Date Of Last Physical Exam: _____

In Case Of Emergency:

Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Renewing members only: Have any previous conditions changed or have any new conditions developed within the last year? If yes, please indicate below, if no, you may stop here. (Please Circle) YES/NO

Have you ever had any of the following? (Please check)

____Heart Attack
____Heart Surgery
____Cardiac Catheterization
____Coronary Angioplasty
____Heart Failure
____Heart Transplantation
____Congenital Heart Disease
____Coronary Heart Disease
____Rheumatic Heart Disease
____Angina
____Heart Murmurs
____Heart Valve Problems
____Stroke
____Diabetes (high blood sugar)
____Hypertension (high blood pressure)
____Epilepsy
____Cancer
____Disease of the kidney, liver or thyroid
____A Pacemaker/Implantable Cardiac Defribillator/Rhythm Disturbance
____Asthma
____Emphysema

Please explain: _____

Are you taking any prescription drugs? If yes, which ones and for what reason?

_____

Are you under a doctor's care? If so, please explain.

_____

Do you have any medical conditions for which a physician has recommended some restrictions on activity? (Please circle) Yes No

If yes, please explain: _____

Do you currently exercise? (Please circle) Yes No
Do you currently smoke? (Please circle) Yes No

Have you ever experienced any of the following (Please check)

	At Rest	During Exercise (Including at work, Climbing stairs & walking)
Pain or discomfort in the chest	_____	_____
Inappropriate shortness of breath	_____	_____
Dizziness, fainting, blackouts	_____	_____
Claudication (poor circulation in legs due to blood clot)	_____	_____

Females only ☺

Are you pregnant? _____Yes ____No If yes, what is your expected due date?_____

Have you had a recent pregnancy? (Last 3 months?) _____Yes _____No

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Has anyone in your immediate family had any of the following before the age of 55?

	Relative:	Age Diagnosed:
Heart Attack	_____	_____
Angina Pectoris (Chest pain)	_____	_____
High Blood lipids (High Cholesterol & Triglycerides)	_____	_____
Stroke	_____	_____
Hypertension (High blood pressure)	_____	_____
Diabetes	_____	_____

Have you ever had any of the following problems concerning your joints muscles and/or supportive tissues? If yes, please indicate the joint/muscle involved

Hernia or Rupture	YES:_____
Arthritis/Bursitis	YES:_____
Back Injury/Pain	YES:_____
Bone Fracture	YES:_____
Joint Dislocation	YES:_____
Tendon, Ligament, Cartilage	YES:_____
Orthopedic Surgery (Bone, muscle or joint related surgery)	YES:_____
Other Surgery	YES:_____
Osteoporosis	YES:_____
Other/Miscellaneous	YES:_____

Have you had your cholesterol measured within the past year? ____Yes ____No
if yes, what was the reading? Total_____ HDL_____ LDL_____

Is there anything else that you would like to tell us about your health/nutrition/family history?

_____

_____

Please sign below acknowledging that the above information is true to the best of your knowledge.

Signature: _____ Date:_____

Thank you for taking the time to fill out this form!