

PRIMARY PARTICIPANT

HEALTH HISTORY

Physician Name: _____ Physician Phone: _____

Date of Last Physical: _____

Do you have or have you had any of the following condition: (Please circle Y or N)

- | | | |
|--|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack | <input type="checkbox"/> Y <input type="checkbox"/> N Heart /Artery Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Asthma |
| <input type="checkbox"/> Y <input type="checkbox"/> N Unusual Fatigue/Dizziness | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Hypoglycemia |
| <input type="checkbox"/> Y <input type="checkbox"/> N High Cholesterol | <input type="checkbox"/> Y <input type="checkbox"/> N Smoking Habit | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes |
| <input type="checkbox"/> Y <input type="checkbox"/> N Lung Disease/Respiratory Condition | <input type="checkbox"/> Y <input type="checkbox"/> N Chronic Back Problem | <input type="checkbox"/> Y <input type="checkbox"/> N Major Surgery |
| <input type="checkbox"/> Y <input type="checkbox"/> N Major Orthopedic Surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis/Bursitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Are you currently pregnant? | | |

If you answered yes to any of the above questions, please explain:

List all drugs/medications you are taking and the reason:

1. _____ 2. _____ 3. _____

Are you aware of any allergies to any medications? Y N If yes, please list: _____

Do you know your resting blood pressure? If yes: _____ / _____

EXERCISE HISTORY

Are you presently involved in a regular exercise program? YES NO
If yes, please list activities/duration/frequency/intensity _____

Are you now or have you ever been on a diet? YES NO
If yes, please explain _____

Do you consider yourself overweight or underweight? YES NO

How many meals do you usually eat per day?

How would you describe your nutrition habits? (Circle) Poor Fair Good

How would you characterize your life? (Circle) Low Stress Moderate Stress High Stress

Are there any other comments you would like to give concerning your health?

FITNESS GOALS

Please check 3 – 5 of your top goals:

- | | | |
|-------------------------------|---------------------------|------------------------------------|
| _____ Improve Strength | _____ Decrease Injury | _____ Improve Conditioning |
| _____ Rehabilitate Injury | _____ Improve Flexibility | _____ Improve Agility/Coordination |
| _____ Gain Muscle/Weight | _____ Improve Nutrition | _____ Decrease Body Fat/Weight |
| _____ Other (please specify): | | |

Please expand on goals or comment on time frame (if appropriate)

I do hereby state that I have, to the best of my knowledge and belief, given a correct and accurate medical history report.

Participant Signature _____ Date _____

SPOUSE

HEALTH HISTORY

Physician Name: _____ Physician Phone: _____

Date of Last Physical: _____

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- | | | |
|--|---|--|
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| <input type="checkbox"/> Y <input type="checkbox"/> N Unusual Fatigue/Dizziness | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Hypoglycemia |
| <input type="checkbox"/> Y <input type="checkbox"/> N High Cholesterol | <input type="checkbox"/> Y <input type="checkbox"/> N Smoking Habit | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes |
| <input type="checkbox"/> Y <input type="checkbox"/> N Lung Disease/Respiratory Condition | <input type="checkbox"/> Y <input type="checkbox"/> N Chronic Back Problem | <input type="checkbox"/> Y <input type="checkbox"/> N Major Surgery |
| <input type="checkbox"/> Y <input type="checkbox"/> N Major Orthopedic Surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis/Bursitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Are you currently pregnant? | | |

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