



HEALTH HISTORY BRIEF

Date: _____

Are currently taking any medications? Y N What? _____

Describe your current exercise program. _____

Do you have or have you had?	Y	N	Please describe.
History of heart problems, chest pain or stroke.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Increased blood pressure.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any chronic illness or condition.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with exercise.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Advice from physician not to exercise.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Serious surgery, illness or injury in the past 12 months.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pregnancy within the past 3 months.	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of breathing or lung problems.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle, joint or back disorder, or previous injury that still affects you.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes or thyroid condition.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cigarette or other smoking habit.	<input type="checkbox"/>	<input type="checkbox"/>	How long? _____
Obesity (more than 20 percent over ideal body weight).	<input type="checkbox"/>	<input type="checkbox"/>	_____
Increased blood cholesterol.	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of heart problems in immediate family.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hernia, or any condition that may be aggravated by lifting weights.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any thing else we should be concerned about.	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please list your goals when working with your trainer/instructor:

Name: _____

Signature: _____

Date: _____