**Health History** Date: \_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Phone/Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health History Circle: (Yes/No)

1. Have you shown any signs of dizziness or shortness of breath with physical activity? Yes/No
2. Have you ever been diagnosed with Diabetes? (Type 1, Type 2) Yes/No
3. Have you ever been diagnosed with high cholesterol? Yes/No
4. Have you **NOT** participated in exercise in the last 3 months (3 days a week)? Yes/No
5. Do you have any past or current muscle/joint injuries, breaks, surgeries or pains? Yes/No

Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you smoked in the last 6 months? Yes/No
2. Has your mother or father ever been diagnosed with any heart conditions? Yes/No
3. Has your doctor ever given you a reason to not participate in physical activity? Yes/No
4. Are you taking any medications? Yes/No

If yes, list:

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 10. If you have said **yes** to **3 or more** questions above please confirm that you have seen your main physician or spoke to them for clearance to exercise. Circle Yes/No if you have seen or spoke with your doctor, include date please.

 Date of clearance by doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes/No

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_