Personal Health History

Name: _____ Date: ____ /____/_____

Medical

Has a doctor or health practitioner ever told you that you have or have had any of the following?

□ Diabetes
□ High Cholesterol
□ Family history of heart disease
□ Cancer
□ High blood pressure
□ Obesity
□ Asthma
□ Arthritis
□ Sleep Apnea and respiratory problems

Do you have any of the following?

□ Joint replacement or repair
□ Back Pain
□ Pacemaker
□ Weak Ankles
□ Balance problems

Are you on any current medications that would affect the following?

□ Heart rate
□ Blood pressure
□ Vision
□ Balance

Please list any other conditions or surgeries I should be aware of when planning your fitness program.

_____
_____

Lifestyle

Smoking:

□ Yes, I smoke. How many cigarettes, how often and how long have you been smoking?
_____
□ No, I Never smoked
□ Occasionally, when out with friends

Drinking (Alcohol): □ Yes □ No □ Occasionally

Job / Work:
Is your current work day sedentary or active?
Do you have to wear heels to work? Y, N or N/A
Does your chair have arm rests? Y or N?

Fitness:

What's your current exercise status?
□ Weekend Warrior
□ Sedentary
□ Monthly (How many times this month? _____)
□ Weekly (How many times this week? _____)
How much time and how frequently can you devote to working out? _____

What are your fitness goal(s)? _____
_____