



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)?

