

Wright Way Fitness

Personal Health And Fitness Medical History Questionnaire

Name: _____ Date of Birth: _____ Age: _____
Phone Number: _____ Date: _____
Email Address: _____

Health History

1. Do you smoke? Yes No
If you answered yes, how much do you smoke? _____
2. Has your doctor ever said your blood pressure was too high or low? Yes No
3. Have you (or a family member) ever been told that you have diabetes? Yes No
4. Do you have any known cardiovascular problems (e.g., heart disease, previous heart attack, atherosclerosis, abnormal electrocardiogram)? Yes No
If you answered yes, please describe. _____
5. Has your doctor ever told you your cholesterol level was high? Yes No
6. Are you overweight? Yes No
If you answered yes, how much are you overweight? _____
7. Do you have any injuries or orthopedic problems (e.g., bad back, bad knees, tendinitis, bursitis)? Yes No
If you answered yes, describe: _____
8. Are you taking any prescribed medications or dietary supplements? Yes No
If so, please describe: _____
9. Are you pregnant or postpartum less than six weeks Yes No
10. Date of last physical examination: _____
11. Do you have any other medical conditions or problems not previously mentioned? Yes No
If you answered yes, please describe: _____
12. Describe you current exercise program: _____

13. List the goals of your program: _____

I acknowledge, to the best of my ability, that I am in good health and have no known medical problems that would restrict my ability to participate in this exercise program.

Signed: _____ Date: _____