Health Screen

Name: ____ Age: _________ Date of Birth: ______________

Physician ____ Phone ____________________

Date of Last Medical Exam _______________

Contact In Case of Emergency ________________________________ Phone ____________________

Have you ever personally experienced any of the following health related difficulties?

Yes No (Please check all that apply)

History of heart disease, chest pain, or stroke?

Immediate family member (blood relative) with history of heart disease or early death?

Do you currently smoke cigarettes or have you quit within the last 6 months?

Do you have a sedentary lifestyle?

Is your BMI greater than 29?

Do you have high blood pressure (systolic > 139 or diastolic > 89)?

Do you have high cholesterol (LDL > 129mg/dL or HDL < 40mg/dL)

Have you been told that your fasting plasma glucose is > 100mg/dL?

History diabetes or any other metabolic disease (thyroid, renal, liver)?

History of pulmonary disease, asthma, lung disease, or cystic fibrosis?

Dizziness/feeling faint?

Major chronic illnesses?

Surgeries?

Spinal injuries or back disorder?

Bone or joint injuries?

Disabilities that may affect your training?

Difficulty reaching or maintaining desirable body weight?

Hernia?

Has your doctor instructed you not to exercise?

Any other condition not mentioned above?

1. Please explain anything marked with a "yes" above:

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2. List any prescribed medications, dietary supplements, or drugs that you currently use or have used in the past 6 months:

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3. Would you like your personal trainer to contact your physician in regards to your training?

Yes No

4. Are you currently under the care of a physician for health matters?

Yes No If yes, explain:

Signature: ____ Date:____/_____/______