



Health/Medical History
Downtown Fitness on Elm

(This information will be kept confidential)

Name: _____ Sex (circle one): M or F
 Date of birth: _____ Age: _____
 Home address: _____
 City/State: _____ Zip code: _____
 Phone: (Home) _____ (Work) _____
 Email: _____ Occupation: _____
 Personal physician: _____ Phone: _____
 Physician's address: _____
 In case of an emergency contact: Name: _____
 Phone: _____ Relationship: _____

Medical History

*Check any conditions or diseases which you now have or have had in the past.

_____ Anemia	_____ Bronchitis
_____ Asthma	_____ Emphysema
_____ Cancer	_____ Chest Discomfort (angina or tightness)
_____ Cardiac Catheterization	_____ Cardiac Arrest
_____ Dizziness/Fainting Spells	_____ Diabetes
_____ Epilepsy/Seizures	_____ Gout
_____ Heart Disease	_____ Heart Murmur
_____ Heart Surgery	_____ Hemorrhoids
_____ High Blood Pressure	_____ Kidney Disease
_____ Nervous/Emotional Problems	_____ Rheumatic Heart Disease
_____ Thyroid Problems	_____ Varicose Veins
_____ Ulcers	_____ Stroke
_____ Low Blood Pressure	_____ Stomach Problems (IBS)
_____ Irregular Heart Beat	_____ Shortness of Breath
_____ Ankle or Leg Swelling	_____ Foot Problems
_____ Joint Pain/Swelling	_____ Back Problems
_____ Knee Problems	_____ Neck Problems
_____ Shoulder Problems	_____ Bursitis
_____ Osteoarthritis	_____ Rheumatoid arthritis

*If you checked any of these, please explain (use the back if necessary): _____

Have you ever had chest discomfort with exercise? Yes No Date of last physical: _____

Have you had your cholesterol level checked in the last year? Yes No What was your results? _____ ml/dL.

Do you take any prescribed medications? Yes No If yes, please list:

Drug: _____ Dosage: _____ x/day for _____ months/ yrs.
Drug: _____ Dosage: _____ x/day for _____ months/ yrs.
Drug: _____ Dosage: _____ x/day for _____ months/ yrs.

Do you take any over-the-counter medications? Yes No. If yes, please list: _____

Life Style Habits

Do you take supplements? If yes, what? _____

Do you smoke? Yes No Amount per day: _____ Years smoking: _____ Date quit: _____

Do you drink alcohol? Yes No (# of drinks per week: _____)

Do you drink sodas? Yes No (# of drinks per week: _____)

Do you drink coffee or tea? Yes No (# of drinks per week: _____)

Has your weight changed in the past year? Yes No (If yes, how much? _____)

How do you feel about your current weight? (Circle one) Satisfied Not Concerned Dissatisfied

How many meals do you eat per day? _____ How would you describe your nutritional habits? Good Fair Poor

Would you like nutritional guidance from your trainer? Yes No

Family History

Have any of your blood relatives (parents, siblings, or grandparents) had:

<u>Age/Relation</u>	<u>Age/Relation</u>	<u>Age/Relation</u>
Heart Attack	Stroke	Cancer
Diabetes	High Blood Pressure	Coronary Artery Disease
Cardiac Arrest	Obesity	Congenital Heart Disease

Physical Fitness Information

Please rate your current level of fitness:

Best Ever Very High Average for Me Poorer than Usual Very Poor

Please list any activities or exercises you currently perform:

Activity: _____	Frequency: _____
Activity: _____	Frequency: _____
Activity: _____	Frequency: _____
Activity: _____	Frequency: _____

List some short term goals: _____

List some long term goals: _____

How did you find out about DownTown Fitness on Elm: _____