Health History Inventory
(short version)

Name:_____ Membership #:_____

Address:_____

Phone (W):_____ Phone (H):_____ Fax:_____

E-mail:_____ Gender:_____ Birthdate:_____

Regular physical activity is enjoyable and healthy, and for most people safe. However, some individuals may have health-related risks that might require them to check with their physician prior to starting an exercise program. To help determine if there is a need for you to see your physician before starting an exercise program, carefully read and answer the following questions. All information will be kept strictly confidential.

I. PHYSICAL ACTIVITY SCREENING QUESTIONS

Yes	No	
❑	❑	1. Has your physician ever told you that you have a heart condition?
❑	❑	2. Do you experience chest pain when you are physically active?
❑	❑	3. In the past month, have you experienced chest pain when not performing physical activity?
❑	❑	4. Do you lose balance because of dizziness or do you ever lose consciousness?
❑	❑	5. Do you have a bone or joint problem that could be aggravated by a change in your level of physical activity?
❑	❑	6. Is your physician currently prescribing medications for your blood pressure or a heart condition?
❑	❑	7. Do you know of any other reason why you should not participate in a program of physical activity?

If you answered yes to any of the questions above, it is recommended that you consult with your physician, by phone or in person, before having a fitness test or participating in a physical-activity program.

II. GENERAL HEALTH HISTORY QUESTIONS (Please answer yes or no to each of the following questions.)

Yes	No	
❑	❑	1. Have you ever had a stroke?
❑	❑	2. Do you have diabetes? If yes, are you currently taking any medications or receiving other treatment related to the diabetes? ❑ Yes ❑ No
❑	❑	3. Do you have asthma or another respiratory condition that causes difficulty with breathing? If yes, please describe._____
❑	❑	4. Do you have any orthopedic conditions that would restrict you in performing physical activity? If yes, please describe._____
❑	❑	5. Have you ever been told by a physician that you have one of the following? (Check applicable boxes)

- ❑ High blood pressure
- ❑ Elevated blood lipids, including elevated cholesterol
- ❑ Cardiovascular disease
- ❑ Cancer
- ❑ Other health/medical condition (please describe):_____

❑	❑	6. Do you currently smoke or have you smoked in the past and stopped within the past six months?
❑	❑	7. Do you currently have back pain or have you had back pain within the past six months or felt discomfort that prevented you from carrying out normal daily activities?
❑	❑	8. Are you currently taking any medications for a health or medical condition? If yes, please indicate which medications you are taking._____
❑	❑	9. Are you pregnant?

If you answered yes to any of the questions above, it is recommended that you consult with your physician, by phone or in person, before having a fitness test or participating in a prescribed physical-activity program. In some instances, depending upon the answers you provided to the questions above, you may be required to obtain a physician's written clearance before an exercise program can be designed for you.

Signature _____ Date _____