AtHomeBeFIT
Functional. Intelligent. Training.
Health History Questionnaire

Name
_____
_____

Date _____ Age_____ Birthday, with year: _____
Gender _____

Physician's Name_____ Physician's Phone
_____

Person to contact in case of emergency:
Name_____
Phone_____

Are you taking any medications, supplements, or drugs? If so, please list medication, dose, and reason.
_____
_____
_____
_____
_____

Does your physician know you are participating in this exercise program?
_____
_____

Describe any physical activity you do somewhat regularly.
_____
_____
_____
_____

Do you now have, or have you had in the past (please feel free to use the space on the back):

1. History of heart problems, chest pain, or stroke

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2. Elevated blood pressure

3. Any chronic illness or condition

4. Difficulty with physical exercise

5. Advice from physician not to exercise

6. Recent surgery (last 12 months)

7. Pregnancy (now or within last 3 months)

8. History of breathing or lung problems

9. Muscle, joint, or back disorder

10. Any previous injury still affecting you

11. Diabetes or metabolic syndrome

12. Thyroid condition

13. Cigarette smoking habit

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14. Obesity [body mass index (BMI) ≥30 kg/m^2]

15. Elevated blood cholesterol

16. History of heart problems in immediate family

17. Hernia, or any condition that may be aggravated by lifting weights or other physical activity

Is there anything else you'd like for me to know about your current health?

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