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HEALTH HISTORY QUESTIONNAIRE

Please answer the following questions to the best of your ability. For the following questions, unless otherwise indicated, circle the single best choice for each question. As is customary, all of your responses are completely confidential and may only be used in group summaries and/or reports. All information collected is subject to the Privacy Act. If you have any physical handicaps or limitations that would require special assistance with this questionnaire, please let your trainer know. This form is in accordance with the American College of Sports Medicine guidelines for risk stratification when followed correctly by your trainer. Your trainer should be certified with a national organization in order to use these forms correctly.

Name: _____ Ht: _____ Wt: _____

Gender: _____ Age: _____ Birthdate: _____ - _____ - _____

Address: _____

City: _____ State: _____ ZIP: _____ Phone: (____) _____

Emergency Contact: _____ Phone: (____) _____

Personal Physician: _____ Phone: (____) _____

E-mail: _____

- 1. Have you ever had a definite or suspected heart attack or stroke? Yes No
- 2. Have you ever had coronary bypass surgery or any other type of heart surgery? Yes No
- 3. Do you have any other cardiovascular or pulmonary (lung) disease (other than asthma, allergies, or mitral valve prolapsed)? Yes No
- 4. Do you have a history of: diabetes, thyroid, kidney, liver disease? (circle all that apply) Yes No
- 5. Have you ever been told by a health professional that you have had an abnormal resting or exercise (treadmill) electrocardiogram (EKG)? Yes No
- 6. If you answered YES to any of Questions 1 through 5, please describe:

- | | | |
|---|-----|----|
| 7. Do you currently have any of the following: | | |
| a. Pain or discomfort in the chest or surrounding areas that occurs when you engage in physical activity? | Yes | No |
| b. Shortness of breath | Yes | No |
| c. Unexplained dizziness or fainting | Yes | No |
| d. Difficulty breathing at night except in upright position | Yes | No |
| e. Swelling of the ankles (recurrent and unrelated to injury) | Yes | No |
| f. Heart palpitations (irregularity or racing of the heart on more than one occasion) | Yes | No |
| g. Pain in the legs that causes you to stop walking (claudicating) | Yes | No |
| h. Known heart murmur | Yes | No |
| • Have you discussed any of the above with your personal physician? | Yes | No |
| 8. Are you pregnant or is it likely that you could be pregnant at this time?
If yes, what is your expected due date? _____ | Yes | No |
| 9. Have you had surgery or been diagnosed with any disease in the past 3 months?
If yes, please list date _____ and surgery/ disease _____ | Yes | No |
| 10. Have you had high blood cholesterol or abnormal lipids within the past 12 months or are you taking medication to control your lipids? | Yes | No |
| 11. Do you currently smoke cigarettes or have quit within the past 6 months? | Yes | No |
| 12. Have your father or brother(s) had heart disease prior to age 55 OR mother or sister(s) had heart disease prior to age 65? | Yes | No |
| 13. Within the past 12 months, has a health professional told you that you have high blood pressure (systolic \geq 140 OR diastolic \geq 90)? | Yes | No |
| 14. Currently, do you have high blood pressure or within the past 12 months, have you taken any medicines to control your blood pressure? | Yes | No |
| 15. Have you ever been told by a health professional that you have a fasting blood glucose greater than or equal to 110 mg/dl? | Yes | No |

26. Please list below all prescription and over-the-counter medications you are currently taking:

Medicine	Reasons for taking	Dosage	Amount/Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

27. Are there any medicines that your physician has prescribed to you in the past 12 months which you are currently not taking? Yes No
If so, please list

I have answered the Health History Questionnaire questions accurately and completely. I understand that my medical history is a very important factor in the development of my fitness/wellness program. **I understand that certain medical or physical conditions which are known to me, but that I do not disclose to Rachel Webster Personal Fitness, may result in serious injury to me. If any of the above conditions change, I will immediately inform Rachel Webster Personal Fitness of those changes. I, knowingly and willingly, assume all risks of injury resulting from my failure to disclose accurate, complete, and updated information in accordance with the attached questionnaire.** I also understand that in order to properly risk stratify my Health History Questionnaire, my trainer should have a minimum of a national certification as a personal trainer. My trainer also verbally explained this statement to me to my understanding.

Client's Signature: _____ Date: _____

Trainer's Signature: _____ Date: _____