

HEALTH AND FITNESS HISTORY

1. Are you presently involved in a regular exercise program? If yes, please list activity, duration, frequency, and intensity:

2. Do you now smoke or have you ever smoked? Yes No

a. If you previously smoked, how long did you smoke, how often, and when did you quit?

b. If you currently smoke, how much?

3. Do you use alcohol? Yes No

a. If yes, how much per day?

b. How much per week?

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

- | | |
|---|---|
| <input type="checkbox"/> Heart attack; coronary bypass or other cardiac surgery | <input type="checkbox"/> Cold hands or feet |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Unusual shortness of breath |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Light-headedness or fainting |
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Epilepsy or seizures |
| <input type="checkbox"/> Phlebitis or emboli | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Chest discomfort | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Extra, skipped, or rapid heart beats | <input type="checkbox"/> A chronic recurrent cough |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Increased stress or depression |
| <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Emotional disorders |
| <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Fatigue or lack of energy |
| <input type="checkbox"/> Migraine or recurrent headaches | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Swollen, stiff, or painful joints | <input type="checkbox"/> Stomach / intestinal problems |
| <input type="checkbox"/> Foot problems | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Limited motion in joints |
| <input type="checkbox"/> Shoulder problems | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Neck problems | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Tendonitis |

If you checked any of these, please explain here.

5. Please list any prescribed medications you are now taking.

6. Please list any over-the-counter medications or dietary supplements you are now taking.

7. Please list any illness, hospitalization, or surgical procedure within the past 2 years.

8. Please check specific goals you would like to achieve:

- | | |
|---|--|
| <input type="checkbox"/> Improve strength | <input type="checkbox"/> Reduce stress |
| <input type="checkbox"/> Improve flexibility | <input type="checkbox"/> Increase energy |
| <input type="checkbox"/> Improve cardiovascular fitness | <input type="checkbox"/> Stop smoking/drinking |
| <input type="checkbox"/> Improve muscle tone and shape | <input type="checkbox"/> Injury prevention |
| <input type="checkbox"/> Improve diet/eating habits | <input type="checkbox"/> Rehabilitate injury |
| <input type="checkbox"/> Lose weight | <input type="checkbox"/> Gain weight/muscle |
| <input type="checkbox"/> Improve athletic performance | <input type="checkbox"/> Additional goals (Please list): |