

HEALTH HISTORY FORM

Name: _____ Date: _____
Address: _____
Phone: _____

HEALTH REPORT

Emergency Contact: _____ Phone: (____) _____
Doctor's Name: _____ Phone: (____) _____

- 1) Are you Currently taking any medication? Yes No

Type: _____ Reason: _____
Type: _____ Reason: _____
Type: _____ Reason: _____

- 2) Do you have or have you ever had any of the following conditions?

<u>CONDITION</u>		<u>DESCRIPTION</u>
Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Thyroid	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

- 3) Have you ever been injured in any of the following areas?

<u>BODY PART</u>		<u>DESCRIPTION</u>
WHEN?		
Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Shoulders	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Arms	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Abdomen	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Back	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Legs _____

Yes No _____

4) Are you currently under the care of a physician for any reason at all?

Yes No If Yes, explain _____

5) Do you smoke cigarettes? Yes No. If yes, how much? _____

6) Do you know of any physical condition that you have that could be aggravated by exercising or exerting yourself?

Yes No If Yes, explain _____

7) Are you taking any medication which could cause a reaction while exercising?

Yes No If Yes, Explain _____

8) Does your doctor know that you are beginning a new exercise program? Yes No

9) If your doctor knows that you are going to begin a new exercise program, does he/she object? Yes No If Yes, why? _____

RELEASE

I know of no physical or medical condition which I, or my Doctor, feel could be aggravated by my using the equipment and facilities or, participating in activities sponsored by this club. I agree to advise club management in writing if any of the above information changes or if my Doctor advises me to stop, reduce, or otherwise adjust my exercise regimen at the club. I will advise club management immediately if I injure myself in anyway while on club property. The information I have given on this form is, to the best of my knowledge, complete and accurate.

Signature _____ Date: _____

(Form #6A)