

# YOUR HEALTH & ACTIVITY HISTORY

<b>Last Name:</b>		<b>First Name:</b>		<b>Referred by:</b>	
<b>Address:</b>				<b>Zip Code:</b>	
<b>Telephone #: Home</b>		<b>Business#</b>		<b>Cell:</b>	
<b>In Case of Emergency, Contact:</b>				<b>Phone#:</b>	
<b>Sex</b> <input type="checkbox"/> M <input type="checkbox"/> F		<b>Age:</b>		<b>DOB:</b>	
		<b>Height:</b>		<b>Weight:</b>	
<b>Personal Physician:</b>				<b>Phone #:</b>	

### Understanding Your Health & Activity History

This form is not a substitute for a thorough physical examination, assessment and diagnosis by your physician. It has been designed to identify adults for whom physical activity might be inappropriate at this time. The Club strongly recommends that each member undergo a medical examination before beginning any program of exercise. Please answer each question accordingly.

<b>1. General History</b>	YES	NO	<b>3. Pulmonary History</b>	YES	NO
- Are you male over 45 or female over 55?	<input type="checkbox"/>	<input type="checkbox"/>	- Do you suffer from pulmonary disease such as asthma or emphysema	<input type="checkbox"/>	<input type="checkbox"/>
- Are you accustomed to regular exercise (3x per week or more)?	<input type="checkbox"/>	<input type="checkbox"/>	<i>Please specify:</i>		
- Do you currently have an illness or infection?	<input type="checkbox"/>	<input type="checkbox"/>	<b>4. Medication History</b>		
<i>Please specify:</i>			- Are you currently taking ANY medication?	<input type="checkbox"/>	<input type="checkbox"/>
- Have you had major surgery or have you been hospitalized with the last year?	<input type="checkbox"/>	<input type="checkbox"/>	If yes: Medication                      Dosage                      Condition		
<i>Please specify:</i>					
- Women's Health: Are you currently pregnant or have you given birth within the last 8 weeks?	<input type="checkbox"/>	<input type="checkbox"/>			
- Do you have a history of the following conditions?			<b>5. Musculoskeletal History</b>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	- Do you have a bone or joint problem such as arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disorders	<input type="checkbox"/>	<input type="checkbox"/>	- Are you correctly receiving physical therapy treatment chiropractic or medical?	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<i>Please specify condition:</i>		
Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>			
			<b>6. Other Medical History</b>		
<b>2. Cardiovascular/Circulatory History</b>			- Is there a good physical reason not mentioned here why you shouldn't follow an activity program if you wanted to?	<input type="checkbox"/>	<input type="checkbox"/>
- Has your doctor said you have heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<i>Please specify:</i>		
<i>Please specify:</i>					
- Do you frequently suffer from pains in your chest?	<input type="checkbox"/>	<input type="checkbox"/>			
- Do you often feel faint or have spells of severe dizziness?	<input type="checkbox"/>	<input type="checkbox"/>			
- Do you have a history of high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
- Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>			
- Do you have a family history of heart disease?	<input type="checkbox"/>	<input type="checkbox"/>			
Relation:	Age:				

## 7. Tell Us What You Do Now

Please check off current activities

Number of times per week per activity

<input type="checkbox"/> Hiking	<input type="checkbox"/> 0-1	<input type="checkbox"/> 1-3	<input type="checkbox"/> 3-5	<input type="checkbox"/> 5+
<input type="checkbox"/> Biking	<input type="checkbox"/> 0-1	<input type="checkbox"/> 1-3	<input type="checkbox"/> 3-5	<input type="checkbox"/> 5+
<input type="checkbox"/> Walking	<input type="checkbox"/> 0-1	<input type="checkbox"/> 1-3	<input type="checkbox"/> 3-5	<input type="checkbox"/> 5+
<input type="checkbox"/> Running	<input type="checkbox"/> 0-1	<input type="checkbox"/> 1-3	<input type="checkbox"/> 3-5	<input type="checkbox"/> 5+
<input type="checkbox"/> Yard Work	<input type="checkbox"/> 0-1	<input type="checkbox"/> 1-3	<input type="checkbox"/> 3-5	<input type="checkbox"/> 5+
<input type="checkbox"/> Cross Country Skiing	<input type="checkbox"/> 0-1	<input type="checkbox"/> 1-3	<input type="checkbox"/> 3-5	<input type="checkbox"/> 5+
<input type="checkbox"/> Free Weights	<input type="checkbox"/> 0-1	<input type="checkbox"/> 1-3	<input type="checkbox"/> 3-5	<input type="checkbox"/> 5+
<input type="checkbox"/> Resistance training machines	<input type="checkbox"/> 0-1	<input type="checkbox"/> 1-3	<input type="checkbox"/> 3-5	<input type="checkbox"/> 5+
<input type="checkbox"/> Rowing	<input type="checkbox"/> 0-1	<input type="checkbox"/> 1-3	<input type="checkbox"/> 3-5	<input type="checkbox"/> 5+
<input type="checkbox"/> Treadmills	<input type="checkbox"/> 0-1	<input type="checkbox"/> 1-3	<input type="checkbox"/> 3-5	<input type="checkbox"/> 5+
<input type="checkbox"/> Stair Climbing	<input type="checkbox"/> 0-1	<input type="checkbox"/> 1-3	<input type="checkbox"/> 3-5	<input type="checkbox"/> 5+
<input type="checkbox"/> Swimming	<input type="checkbox"/> 0-1	<input type="checkbox"/> 1-3	<input type="checkbox"/> 3-5	<input type="checkbox"/> 5+
<input type="checkbox"/> Racquetball	<input type="checkbox"/> 0-1	<input type="checkbox"/> 1-3	<input type="checkbox"/> 3-5	<input type="checkbox"/> 5+
<input type="checkbox"/> Squash	<input type="checkbox"/> 0-1	<input type="checkbox"/> 1-3	<input type="checkbox"/> 3-5	<input type="checkbox"/> 5+
<input type="checkbox"/> Other, please specify	<input type="checkbox"/> 0-1	<input type="checkbox"/> 1-3	<input type="checkbox"/> 3-5	<input type="checkbox"/> 5+

## 8. Activity Interests

This section will be used to help design an individualized exercise program for you. Please select your fitness interests accordingly.

### Interests

<input type="checkbox"/> Weight Reduction
<input type="checkbox"/> Muscle Toning
<input type="checkbox"/> Cardiovascular Training
<input type="checkbox"/> General Fitness Training
<input type="checkbox"/> Flexibility
<input type="checkbox"/> Body Building
<input type="checkbox"/> Nutrition
<input type="checkbox"/> Stress Reduction
<input type="checkbox"/> Club Activities (social)
<input type="checkbox"/> Wellness Seminars
<input type="checkbox"/> Aerobics Classes
<input type="checkbox"/> Other, please specify

I understand the nature and purpose of the health & Activity History and I am aware that any strenuous physical activities involves risks. Accordingly, I release, discharge, absolve and hold harmless the Center, the Club, their agents and employees and instructors, from any and all liability arising out of any accident, injury or loss sustained by me as a result of gross negligence and willful misconduct of the Center and/or Club. I declare to the best of my knowledge, my answers are true, correct and complete.

Signature \_\_\_\_\_ Date \_\_\_\_\_

H & AH reviewed by: Signature \_\_\_\_\_ Date \_\_\_\_\_

### FOR STAFF USE ONLY

#### Testing Required:

MD Clearance  First Club Visit – Date \_\_\_\_\_ Time \_\_\_\_\_

**Would you like to have a body fat analysis and measurements so that we can monitor your progress with us?**

Date \_\_\_\_\_  
 BF% \_\_\_\_\_  
 Chest \_\_\_\_\_  
 Waist \_\_\_\_\_  
 Hips \_\_\_\_\_  
 Right arm \_\_\_\_\_  
 Left arm \_\_\_\_\_  
 Left thigh \_\_\_\_\_  
 Right thigh \_\_\_\_\_  
 Re-exam date \_\_\_\_\_