Health History Questionnaire

All client information is kept confidential and will only be used by authorized personnel to ensure you are being provided a safe and effective workout environment.

Date of Birth ____/____/____   Age ______   Height (ft’ in”) _________   Weight (lb.) _______   Sex _______

YES   NO

☐ ☐ Do you have any personal history of heart disease, chest pains, or stroke?
☐ ☐ Any personal history of diabetes or other metabolic disease (thyroid, renal, liver)?
☐ ☐ Any personal history of pulmonary disease, asthma, or cystic fibrosis?
☐ ☐ Any personal history of low or high cholesterol?
☐ ☐ Do you experience any light-headedness or chest pains during physical activity?
☐ ☐ Have you had any problems with dizziness or fainting?
☐ ☐ Do you have difficulty breathing at any time of day or night?
☐ ☐ Have you experienced a rapid throbbing or fluttering of the heart?
☐ ☐ Do you suffer from joint edema (swelling)?
☐ ☐ Do you experience any joint or bone pain during physical activity?
☐ ☐ Do you have a known heart murmur?
☐ ☐ Do you suffer from health issues related to blood pressure?
☐ ☐ Are you a smoker or have you quit smoking within the last 6 months?
☐ ☐ Do you drink alcohol more than three times per week?
☐ ☐ Do you have a Body Mass Index (BMI) of 25 (kg/m²) or over?
☐ ☐ Are you currently expecting or plan to become pregnant within the next six months?
☐ ☐ Would you characterize your lifestyle as sedentary?
☐ ☐ Have you ever been advised to exercise by a physician or medical professional?
☐ ☐ Do you have any family history of cardiac, metabolic, or pulmonary disease?

When were you last seen by a physician? ______________________________________________________

Has your physician imposed any physical activity restrictions? If yes, please describe. ___________________________________________________________
Check any of the following which currently apply or have previously applied to you:

- [ ] Heart Problems
- [ ] Chest Pains
- [ ] Shortness of Breath at Rest
- [ ] Fainting or Dizziness
- [ ] Allergies
- [ ] Low or High Blood Pressure
- [ ] Seizures
- [ ] Diabetes
- [ ] Lower Back Pain
- [ ] Anemia
- [ ] Asthma
- [ ] Arthritis or Gout
- [ ] Anxiety or Depression
- [ ] Hernia
- [ ] Bodily Pains
- [ ] Acute Infection
- [ ] Cancer
- [ ] Recent Surgery (last 12 mo.)
- [ ] Recent Bone Injury
- [ ] Stomach Problems
- [ ] Pregnant or Recently within the last 3 months

Please explain any conditions you checked above (i.e. treatment, symptoms, and restrictions).

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Have you been told you have high cholesterol levels by your doctor?
If yes, please list cholesterol levels and any interventions currently being used to manage your cholesterol.

________________________________________________________________________________________
________________________________________________________________________________________

Are you currently taking any medications, supplements, or drugs (prescribed or un-prescribed)?
If yes, please list and explain.

________________________________________________________________________________________
________________________________________________________________________________________

Are there any other medical conditions or health issues, both past and present, not previously mentioned that may affect your ability to exercise?
If yes, please explain.

________________________________________________________________________________________
________________________________________________________________________________________

I, ______________________________________, verify that I have informed SFSU Campus Recreation and my Personal Trainer of any existing medical conditions that might require special consideration or clearance before beginning an exercise program. I further certify that my answers stated on both the Physical Activity Readiness Questionnaire and Health History Questionnaire are true and complete. I also understand that this information is an important component of my initial consultation and that I may be asked to update information periodically. Additionally, it is my responsibility to inform my Personal Trainer of any changes in medical condition.

________________________________________  __________________________________________
Client Signature       Date