



Physician's Name \_\_\_\_\_ Phone( ) \_\_\_\_\_  
 Office Location \_\_\_\_\_

Does your physician or specialist know you are participating in this program? Yes No

Do you now or have you had in the past:	Yes	No
1) History of heart problems in family? (mother, father, sibling, grandparent) How old were they?		
2) Cigarette smoking or other tobacco habit?		
3) Elevated blood pressure or taking blood pressure medication?		
4) High cholesterol, triglycerides, or on lipid lowering medications? What is your Total Cholesterol Level?		
5) Diabetes or thyroid condition, impaired fasting glucose?		
6) Any chronic illness or condition? Please Explain:		
7) Difficulty with physical exercise?		
8) Advice from medical professional not to exercise?		
9) Recent surgery? (last 12 months) Please List:		
10) Pregnancy (now or within last 3 months)?		
11) History of allergy, breathing or lung problems?		
12) Muscle, joint, or back disorder, or nay previous injury still affecting you? Please Explain:		
13) A heart condition or heart vascular disease?		
14) Do you have pain, discomfort, or other anginal equivalent in the chest, Neck, jaw, arms, or other areas that may be due to lack of blood flow?		
15) Dizziness or fainting?		
16) Troubled or rapid breathing at night or the need to sit up to breath?		
17) Ankle or leg swelling?		
18) Rapid heat beating or palpitations?		
19) A known heart murmur?		
20) Unusual fatigue or shortness of breath with usual activities?		

Current Weight \_\_\_\_\_ What do you feel is your ideal weight? \_\_\_\_\_

What are your personal fitness goals? What do you hope to accomplish through personal training?

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