

FITNESS ON THE RUN
Health History Form

Name: _____ Date: _____

Date of Birth: _____ Sex: _____

Phone: (cell) _____ (home) _____

E-mail: _____

Home Address: _____

Physician's Name: _____

Physician's Phone Number: _____

Name of Emergency Contact: _____

Phone: _____ Relationship: _____

Are you taking any medications or drugs? If so, please list medication(s) and reason: _____

Do you now have or have you had in the past (check yes or no)

- | | | |
|--|------------------------------|-----------------------------|
| 1. Heart problems, chest pain, or stroke | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. High or low blood pressure | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Any chronic illness or condition | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Difficulty with physical exercise | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Recent surgery (last 2 years) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. Pregnancy (now or within last 3 months) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7. History of breathing or lung problems | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 8. Muscle, joint or back disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 9. Any previous injury still affecting you | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 10. Diabetes or Thyroid condition | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 11. Cigarette smoking habit | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 12. Increased blood cholesterol | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 13. History of heart problems in immediate family | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 14. Hernia, or any condition that may be aggravated by lifting weights | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 15. Advice from physician not to exercise | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Please explain any "yes" answers: _____

Describe any other important information we should be aware of that could impact your exercise program:

List any high school or college sports that you participated in: _____

Note: It is highly recommended that you consult with your physician prior to beginning any new exercise program.