DownTown Fitness on Elm
PERSONAL TRAINERS FOR LIFE

Health/Medical History
DownTown Fitness on Elm

(This information will be kept confidential)

Name:_____ Sex (circle one): M or F
Date of birth:_____ Age:_____
Home address:_____
City/State:_____ Zip code:_____
Phone: (Home)_____ (Work)_____
Email:_____ Occupation:_____
Personal physcian:_____ Phone:_____
Physcian's address:_____
In case of an emergency contact: Name: _____
Phone:_____ Relationship:_____

Medical History

*Check any conditions or diseases which you now have or have had in the past.

_____ Anemia
_____ Asthma
_____ Cancer
_____ Cardiac Catherization
_____ Dizziness/Fainting Spells
_____ Epilepsy/Seizures
_____ Heart Disease
_____ Heart Surgery
_____ High Blood Pressure
_____ Nervous/Emotional Problems
_____ Thyroid Problems
_____ Ulcers
_____ Low Blood Pressure
_____ Irregular Heart Beat
_____ Ankle or Leg Swelling
_____ Joint Pain/Swelling
_____ Knee Problems
_____ Shoulder Problems
_____ Osteoarthritis
_____ Bronchitis
_____ Emphysema
_____ Chest Discomfort (angina or tightness)
_____ Cardiac Arrest
_____ Diabetes
_____ Gout
_____ Heart Murmur
_____ Hemorrhoids
_____ Kidney Disease
_____ Rheumatic Heart Disease
_____ Varicose Veins
_____ Stroke
_____ Stomach Problems (IBS)
_____ Shortness of Breath
_____ Foot Problems
_____ Back Problems
_____ Neck Problems
_____ Bursitis
_____ Rheumatoid arthritis

*If you checked any of these, please explain (use the back if necessary):_____
_____
_____
_____

Have you ever had chest discomfort with exercise? Yes No Date of last physical:_____

Have you had your cholesterol level checked in the last year? Yes No What was your results? _____ml/dL.

Do you take any prescribed medications? Yes No If yes, please list:
Drug:_____ Dosage:_____ x/day for_____months/yrs.
Drug:_____ Dosage:_____ x/day for_____months/yrs.
Drug:_____ Dosage:_____ x/day for_____months/yrs.

Do you take any over-the-counter medications? Yes No. If yes, please list:_____
_____

Life Style Habits

Do you take supplements? If yes, what?_____

Do you smoke? Yes____ No____ Amount per day:_____ Years smoking:_____ Date quit:_____

Do you drink alcohol? Yes____ No____ (# of drinks per week:_____)
Do you drink sodas? Yes____ No____ (# of drinks per week:_____)
Do you drink coffee or tea? Yes____ No____ (# of drinks per week:_____)

Has you weight changed in the past year? Yes No (If yes, how much?_____)

How do you feel about your current weight? (Circle one) Satisfied Not Concerned Dissatisfied

How many meals do you eat per day?_____ How would you describe your nutritional habits? Good____ Fair____ Poor____

Would you like nutritional guidance from your trainer? Yes____ No____

Family History

Have any of your blood relatives (parents, siblings, or grandparents) had:

Age/Relation	Age/Relation	Age/Relation
_____Heart Attack	_____Stroke	_____Cancer
_____Diabetes	_____High Blood Pressure	_____Coronary Artery Disease
_____Cardiac Arrest	_____Obesity	_____Congenital Heart Disease

Physical Fitness Information

Please rate your current level of fitness:

_____Best Ever _____Very High _____Average for Me _____Poorer than Usual _____Very Poor

Please list any activities or exercises you currently perform:

Activity:_____ Frequency:_____
Activity:_____ Frequency:_____
Activity:_____ Frequency:_____
Activity:_____ Frequency:_____
Activity:_____ Frequency:_____

List some short term goals:_____
_____

List some long term goals:_____
_____

How did you find out about DownTown Fitness on Elm:_____