UPPER LEVEL **FITNESS**

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Health History Questionnaire

NAME _____ AGE _____ DOB _____ GENDER: M ☐ F ☐

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME TELEPHONE _____ WORK TELEPHONE _____ MOBILE TELEPHONE _____

EMERGENCY CONTACT NAME _____ CONTACT TELEPHONE _____

HEIGHT _____ WEIGHT (CURRENT) _____ WEIGHT (1 YEAR AGO) _____

HAVE YOU EXERCISED WITHIN THE PAST SIX MONTHS? YES ☐ NO ☐ (IF YES) TYPE OF EXERCISE _____

ARE YOU DIETING? YES ☐ NO ☐ (IF YES) TYPE OF DIET _____ EATING HABITS _____

PACKS OF CIGARETTES SMOKED WEEKLY _____ ALCOHOLIC BEVERAGES CONSUMED WEEKLY _____

CUPS OF COFFEE OR TEA CONSUMED DAILY _____ CANS OF COLA DRINKS CONSUMED DAILY _____

HEALTH HISTORY: INDICATE ANY DISEASE OR ILLNESSES YOU HAVE HAD OR CURRENTLY HAVE

☐ ASTHMA	☐ ALLERGIES	☐ ARTHRITIS	☐ BACK CONDITION
☐ HIGH BLOOD PRESSURE	☐ LOW BLOOD PRESSURE	☐ BURSITIS	☐ FATIGUE
☐ JOINT PAIN	☐ ULCERS	☐ HEART CONDITION	☐ HEMORRHOIDS
☐ HERNIA	☐ NERVOUS TENSION	☐ SINUS	☐ VARICOSE VEINS
☐ EPILEPSY	☐ SHORTNESS OF BREATH	☐ OTHER _____	

ARE YOU CURRENTLY TAKING ANY MEDICATION? YES ☐ NO ☐ SPECIFY TYPE AND DOSAGE _____

WHEN WAS YOUR LAST PHYSICAL EXAMINATION? _____ PHYSICIANS NAME _____ PHONE _____

HAVE YOU HAD A STRESS TEST? YES ☐ NO ☐ CHOLESTEROL PROFILE: HDLS _____ LDLS _____ TOTAL _____