Health History & Emergency Contacts Form

Name: _____ Date of Birth: _____

Address: _____Sex: _____

Physician's Name: _____ Physician's Phone #: (___) ____–_____

REGULAR EXERCISE IS ASSOCIATED WITH MANY HEALTH BENEFITS, YET ANY CHANGE OF ACTIVITY MAY INCREASE THE RISK OF INJURY. COMPLETION OF THIS QUESTIONNAIRE IS THE FIRST STEP WHEN PLANNING TO INCREASE THE AMOUNT OF PHYSICAL ACTIVITY IN YOUR LIFE. PLEASE READ EACH QUESTION CAREFULLY AND ANSWER EVERY QUESTION HONESTLY.

What is the present state of your general health? _____ Blood Pressure: ____/____

1. Yes No Has a physician ever said you have a heart condition and you should only do physical activities recommended by a physician?
2. Yes No When you do physical activity, do you feel chest pain?
3. Yes No When you were not doing physical activity, have you had chest pain in the past month?
4. Yes No Do you ever lose consciousness or do you lose your balance because of dizziness?
5. Yes No Do you have a joint or bone problem that may be made worse by a change in your physical activity?
6. Yes No Is a physician currently prescribing you medications for a blood pressure or heart condition?
7. Yes No Are you now or have you been pregnant in the past 3 months?
8. Yes No Have you had a recent surgery (within the past 3 months)?
9. Yes No Do you have insulin dependent diabetes?
10. Yes No Do you have any other reason you should not exercise or increase your activity?

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, WE NEED TO OBTAIN PERMISSION FROM YOUR DOCTOR BEFORE YOU BECOME MORE PHYSICALLY ACTIVE. DO WE HAVE YOUR PERMISSION TO OBTAIN A MEDICAL CLEARANCE FROM YOUR DOCTOR? YES____ NO____ (*PLEASE CHECK ONE)*

Signature: _____ Date: _____

Emergency Contacts:

Name: _____ Relation: _____

Phone #1:_____ Phone #2: _____

Alternate Contact: _____ Relation: _____

Phone #1:_____ Phone #2: _____