

MUW Personal Training
Health History Form

Name: _____ Date: _____

Phone: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

In case of emergency,
contact: _____ Relationship: _____ Phone: _____

Physician: _____ Specialty: _____

Address: _____ Phone: _____

Are you currently under a doctor's care? Yes No

If yes, please
explain: _____

Date of last physician checkup: _____

Have you ever had a stress test? Yes No Don't know
If yes, what were the results? Normal Abnormal

Do you take any medications on a regular basis? Yes No

If yes, please list medications and reasons for
taking: _____

Have you been recently hospitalized? Yes No

If yes, please
explain: _____

Do you smoke? Yes No

Have high blood pressure? Yes No

Have high cholesterol? Yes No

Diabetes? Yes No

Have parents or siblings who, prior to age 55, had:

Heart attack? Yes No

Stroke? Yes No

High blood pressure? Yes No

High cholesterol? Yes No

Have known heart disease? Yes No

Rheumatic heart disease? Yes No

Heart murmur? Yes No

Chest pain with exertion? Yes No

- | | | |
|--|------------------------------|-----------------------------|
| Irregular heartbeat or palpitations? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lightheadedness or fainting? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Emphysema? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other metabolic disorders (thyroid, kidney, etc.)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Epilepsy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Back pain: upper, middle, lower? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other joint pain (explain)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Muscle pain or injury (explain)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you pregnant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

I attest that the above information is true to the best of my knowledge and acknowledge that I understand the information will be utilized for fitness assessment purposes. I realize that if the information is incorrect it may result in harm to me. The Wellness Program staff may require a physician's clearance before the fitness assessment is conducted.

Signature: _____ Date: _____

Trainer's name: _____ Trainer's signature: _____