Health History Questionnaire

Demographic Information

Name: _______________________________ Gender: ________ Age: __________
Department: __________________________ Campus Address: ________________
Campus Phone: ________________________ Email Address: _________________
Cell Phone: ___________________________ Home Phone: _________________

Emergency Contact Information

Campus Emergency Contact: _______________ Phone: _________________
Personal Emergency Contact: _______________ Phone: _________________
Primary Physician: ________________________ Phone: _________________
Physician’s Address: _____________________________________________________________________

Medical History

Do you have, or have you ever had, any of the following? Check Yes or No

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If you answered ‘Yes’ to any of the above, please explain in detail below (including current status, dates, and duration of treatment where applicable):

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Current Medications that affect your ability to exercise:
_____________________________________________________________________________________
Please answer the following questions to the best of your knowledge.

1. Have you, or any of your immediate family, been diagnosed with heart/artery disease?
   - □ I have been diagnosed with heart/artery disease
   - □ Immediate family member (mother, father, siblings) diagnosed younger than 50 years of age
   - □ Immediate family member (mother, father, siblings) diagnosed older than 50 years of age
   - □ No history of heart/artery disease

2. Do you Smoke? □ Yes □ No
   If yes, how many cigarettes/cigars do you smoke per day? _______
   If you have smoked in your lifetime, but do not smoke any longer, when did you quit? ___/___/____

3. What is your current physical activity level?
   - □ None
   - □ Somewhat active
   - □ Moderately active
   - □ Very active

4. If you are currently active, please describe the type of activity, duration, and frequency:
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________

5. What are your fitness goals?
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________

6. Please describe any physical limitations (injuries, chronic conditions, medications, etc.) that your trainer should be aware of when designing your program:
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________

7. Please describe any personal limitations (workload, travel, family obligations, etc.) that your trainer should be aware of when designing your program:
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________

8. What facility would you prefer to work train?
   - □ Employee Fitness Center
   - □ Personal Training Studio
   - □ Student Fitness Center
9. What is your availability throughout the week?
   - Monday:______________________________________________________________
   - Tuesday:______________________________________________________________
   - Wednesday:___________________________________________________________
   - Thursday:_____________________________________________________________
   - Friday:_______________________________________________________________

10. When do you want to start personal training? How often would you like to train?
   - Start Date:______________________________________________________________
   - 1x a month
   - 2x a month
   - 1x a week
   - 2x a week
   - Other:_______________________________________________________________

11. Male or Female-Personal Trainer preference? (Please circle one.)

12. Please list any additional information you feel would be valuable for your trainer to know:
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________