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 be personally trained in?
   □ 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. Please list any additional information you feel would be valuable for your trainer to know:
    ____________________________________________________________________
    ____________________________________________________________________
    ____________________________________________________________________
    ____________________________________________________________________
    ____________________________________________________________________
    ____________________________________________________________________