GETMOOREFITNESS

HEALTH HISTORY QUESTIONNAIRE

Please fill out this form as accurately as possible. It is essential not only for your safety, but so that we are able to develop a fitness program to fit your needs and potential limitations.

Name: _____

Age: _____ Gender: _____ Height: _____ Weight: _____

Address/City/Zip: _____

Cell Phone: _____ Email: _____

Occupation: _____

DO YOU HAVE OR HAVE YOU EVER HAD:

Been hospitalized	Yes/No
Heart Attack or Heart Trouble	Yes/No
Chest Pain or Angina Pectoris	Yes/No
Coronary Bypass or Angioplasty	Yes/No
Abnormal or Positive Exercise Test	Yes/No
Heart Murmur- Documented by a Physician	Yes/No
Irregular Heart Beat or Rhythm- Documented by a Physician	Yes/No
High Blood Pressure- Above 145/95	Yes/No
Impaired Circulation	Yes/No
Stroke	Yes/No
Convulsions or Loss of Consciousness	Yes/No
Diabetes Mellitus or Insulin Resistance	Yes/No
High Blood Cholesterol	Yes/No
Pregnant	Yes/No
Cigarette Smoker	Yes/No
Musculoskeletal Limitations of Movement	Yes/No
Asthma/Difficulty Breathing/Shortness of Breath	Yes/No
Lupus/Auto-Immune Disorder: _____	Yes/No
Arthritis, Rheumatism	Yes/No
Knee Problems	Yes/No
Chronic or Recurrent Cough/COPD	Yes/No
Anxiety or Depression	Yes/No
Swollen, Stiff or Painful Joints	Yes/No
Back Pain/Spinal Issues/Herniated or Ruptured Disc	Yes/No
Shoulder Pain/Issues	Yes/No
Surgery	Yes/No
Cancer	Yes/No

Other: _____

IMPORTANT: If you answered YES to any of the previous questions, please describe below in detail.

_____

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Name of Physician: _____

Address: _____

Phone Number: _____

I certify to the best of my knowledge that the above information is correct and complete. I also understand that GetMooreFitness assumes no responsibility for any illness, accident, or injury I may incur from the use of its programs, services, or facilities. ***All individuals are strongly encouraged to consult with a physician before entering a non-medically supervised exercise program.***

Signature: _____ Date: _____