Personal Training Program
Health History Questionnaire

NAME: ___________________________________________ TODAY’S DATE: __________

PHONE #: ______________________________ AGE: ______________________

EMAIL ADDRESS: _______________________________________________________

EMERGENCY CONTACT INFORMATION

NAME: ________________________________________________________________

RELATIONSHIP: _______________________________________________________

PHONE #: ___________________________________________________________

PHYSICAL ACTIVITY

CURRENT LEVEL OF PHYSICAL ACTIVITY PER WEEK: (CIRCLE ONE)

0-60 minutes 1-3 hours 4-7 hours Other: __________

HOW LONG HAVE YOU BEEN EXERCISING REGULARLY? (CIRCLE ONE)

Not Currently Active 1-6 months 7-12 months 12+ months

WHAT IS YOUR DESIRED LEVEL OF PHYSICAL ACTIVITY PER WEEK? (CIRCLE ONE)

0-60 minutes 1-3 hours 4-7 hours Other: __________
Please circle any symptoms you are currently experiencing or mark the circle if you are not experiencing any of these symptoms.

<table>
<thead>
<tr>
<th>Category</th>
<th>Symptoms</th>
<th>No Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>Appetite change     Fatigue               Fever Sweats Weight loss Weight gain Weakness</td>
<td>o</td>
</tr>
<tr>
<td>Skin</td>
<td>Itching Rash Mole change</td>
<td>o</td>
</tr>
<tr>
<td>Eyes</td>
<td>Vision change Cataracts Glaucoma</td>
<td>o</td>
</tr>
<tr>
<td>Ears/Nose/Mouth</td>
<td>Dizziness Ringing in ears Sore throat Runny nose Nosebleeds</td>
<td>o</td>
</tr>
<tr>
<td>Lungs</td>
<td>Cough Shortness of breath Chest pain Coughing up blood Wheezing</td>
<td>o</td>
</tr>
<tr>
<td>Heart</td>
<td>Chest pain Palpitations Fainting</td>
<td>o</td>
</tr>
<tr>
<td>GI</td>
<td>Abdominal pain Nausea Vomiting Diarrhea Constipation Jaundice Blood in stool Difficulty swallowing</td>
<td>o</td>
</tr>
<tr>
<td>Urinary</td>
<td>Painful urination Increased frequency Urgency Blood in urine Kidney stones</td>
<td>o</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Arthritis Stiffness Swelling Weakness Backache</td>
<td>o</td>
</tr>
<tr>
<td>Nervous System</td>
<td>Headache Seizure Dizziness Memory loss Numbness/tingling Anxiety Depression Personality change</td>
<td>o</td>
</tr>
<tr>
<td>Reproductive</td>
<td>(M) Testicular pain (M) Swelling (W) Pelvic pain (W) Abnormal bleeding</td>
<td>o</td>
</tr>
<tr>
<td>Hematologic</td>
<td>Bruising Bleeding Recurring infections</td>
<td>o</td>
</tr>
</tbody>
</table>
**Past History**
- Check if you’ve had...
  - Rheumatic Fever
  - Heart Murmur
  - High Blood Pressure
  - Disease of the arteries
  - Heart Attack
  - Chest Pain
  - Stroke Cancer
  - Lymphedema
  - Lung Disease
  - Epilepsy
  - Diabetes
  - Varicose Veins
  - Injuries to Back
  - Injuries to Knees, etc.
  - Surgery
  - Other

**Family History**
- (Including parents, grandparents, siblings)...
  - Have any relatives had...
    - Heart Attacks
    - High Blood Pressure
    - Heart Operations
    - Congenital Heart Disease
    - Cancer
    - Diabetes
    - Other Major Illness

**Present Symptoms/Conditions**
- Do you experience...
  - Chest Pains
  - Heart Palpitations
  - High Blood Pressure
  - Cancer
  - Lymphedema
  - Shortness of Breath
  - Back Pain
  - Arthritis
  - Swollen Legs
  - Other

**Past History**
- Rheumatic Fever
- Heart Murmur
- High Blood Pressure
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- Heart Attack
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- Epilepsy
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- Surgery
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**Family History**
- Heart Attacks
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- Cancer
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- Other Major Illness

**Present Symptoms/Conditions**
- Chest Pains
- Heart Palpitations
- High Blood Pressure
- Cancer
- Lymphedema
- Shortness of Breath
- Back Pain
- Arthritis
- Swollen Legs
- Other

**Explain each checked item:**

- 
- 
- 

**Hospitalizations/Surgeries**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
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<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
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</table>

**All Allergies Reaction**

<table>
<thead>
<tr>
<th>Reaction</th>
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<tr>
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I understand that completion of the Health History Questionnaire is required prior to my participation in a Personal Training Program. I certify that all information I have provided on this form is true and accurate. I will notify the program staff of any changes in my health.

**Name:**

**Date:**

**Signature:**

Personal Training Program-HHQ Form-Updated 12/2022