



## Health/Medical History Questionnaire

*This information is used solely as an aid. It will not be released without your knowledge and consent.*

Name \_\_\_\_\_ Date \_\_\_\_\_ Birth date \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Phone Number: \_\_\_\_\_ Email \_\_\_\_\_

*Personal Physician:*

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

## **Personal Training Par-Q(Physical Activity Readiness Questionnaire)**

- | <u>YES</u>               | <u>NO</u>                |                                                                                                                                            |
|--------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Has your doctor ever said that you have a heart condition <u>and</u> that you should only do physical activity recommended by a doctor? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Do you feel pain in your chest when you do physical activity?                                                                           |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. In the past month, have you had chest pain when you were not doing physical activity?                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you lose your balance because of dizziness or do you ever lose consciousness?                                                        |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by change in your physical activity?      |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?                       |

**If you checked “yes” for any question #1-#6, the “National Strength and Conditioning Association” states that you must receive clearance from your physician prior to participating in a progressive resistance exercise program. Download the “Physician Clearance” Form from [www.fitwithz.com](http://www.fitwithz.com).**

*I have read this entire document and have answered all of the questions to the best of my knowledge.*

\_\_\_\_\_  
Last Name, First Name (print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Medical History

### Present & Past History

Have you had or do you presently have any of the following conditions? (Check if yes.)

- Rheumatic fever
- Recent operation
- Edema (swelling of ankles)
- High blood pressure
- Injury to back or knees
- Low blood pressure
- Seizures
- Lung disease
- Heat attack
- Fainting or dizziness
- Diabetes
- High cholesterol
- Orthopnea (the need to sit up to breathe comfortably) or paroxysmal (sudden, unexpected attack) nocturnal dyspnea (shortness of breath at night)
- Shortness of breath at rest or with mild exertion
- Chest pains
- Palpitations or tachycardia (unusually strong or rapid heartbeat)
- Intermittent claudication (calf cramping)
- Pain, discomfort in the chest, neck jaw, arms, or other areas
- Known heart murmur
- Unusual fatigue or shortness of breath with usual activities
- Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side, arm, or leg
- Other



**Family History**

Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions? (Check if yes.) In addition, please identify at what age the condition occurred.

- Heart attack
- Heart operation
- Congenital heart disease
- High blood pressure
- High cholesterol
- Diabetes
- Other major illness \_\_\_\_\_

Explain checked items:

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**Activity History**

1. How were you referred to this program? (Please be specific.)

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2. Why are you enrolling in this program? (Please be specific.)

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3. Are you presently employed? Yes\_\_ No\_\_

4. What is your present occupational position?

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5. Name of company:

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6. Have you ever worked with a personal trainer before? Yes\_\_ No\_\_

7. Date of your last physical examination performed by a physician:

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8. Do you participate in a regular exercise program at this time? Yes\_\_ No\_\_ \

ACTIVITY

FREQUENCY

9. Can you currently walk 4 miles briskly without fatigue? Yes\_\_ No\_\_

10. Have you ever performed resistance training exercises in the past? Yes\_\_ No\_\_

11. Do you have injuries (bone or muscle disabilities) that may interfere with exercising?

Yes\_\_ No\_\_

If yes, briefly describe: \_\_\_\_\_

12. Do you smoke? Yes\_\_ No\_\_

If yes, how much per day and what was your age when you started?

Amount per day\_\_\_\_\_ Age\_\_\_\_\_

13. How high is the level of stress in your life? HIGH MODERATE LOW

14. What is your body weight now? \_\_ What was it one year ago? \_\_ At age 21 \_\_

15. Do you consider yourself:

- 1) At my goal weight/body composition for maintenance
- 2) At a weight lower than optimal for health and fitness
- 3) At a weight higher than optimal for health and fitness

16. Do you follow or have you recently followed any specific dietary intake plan, and in general how do you feel about your nutritional

habits? \_\_\_\_\_

17. List the medications, nutritional supplements(s)/herbs, etc. you are presently taking.

Medication, supplement or herb

Dosage

Frequency

18. Please list restaurants where you frequently eat and how often you eat out:

