Name Date Phone #

Sex F M Age Weight Height

Physician's Name Phone #

Emergency Contact

Name Relationship Phone #

Prescriptions or Medications?

Did you consult your physician before beginning this exercise program?

Describe your current exercise program.

Do you now, or have you in the past:	Yes	No
1.History of heart problems, chest pain or stroke.		
* **2.Increased blood pressure. If yes, medication?**		
3.Any chronic illness or condition?		
4.Difficulty with physical exercise?		
5.Advice from a physician not to exercise?		
6.Recent surgery (last 12 months)?		
7.Pregnancy?(now or last 3 months)?		
8.History of breathing or lung problems?		
9.Muscle, joint back disorder or any previous injury still affecting you?		
* **10.Diabetes or thyroid condition?**		
* **11.Cigarette smoking habit?**		
12.Obesity (20% or more over ideal body weight)?		
* **13.Increased blood cholesterol level?**		
* **14.History of heart problems in immediate family?**		
15.Hernia, or any condition that may be aggravated?		
16.Please explain any "Yes" answers on the back		

*** "Yes" to one or more of these questions increases risk of injury during exercise.**