PO Box 936, Canby Ore 97013

Club Fit

HEALTH HISTORY FORM

Name: _____ Date: _____

Address: _____

Phone: (day) _____ (eve) _____ Sex: ___Male ___Female

Physician's Name: _____

Physician's Phone: _____

Person to contact in case of emergency:

Name: _____

Phone (day) _____ (eve) _____

Are you taking any medications or drugs? If so, please list medication, dose, and reason. _____

_____

_____

Does your physician know you are participating in this exercise program? ___ Yes ___ No

Describe any physical activity you do somewhat regularly.

_____

_____

Do you now or have you had in the past:

	Yes	No
1. History of heart problems, chest pain or stroke	☐	☐
2. Increased blood pressure	☐	☐
3. Any chronic illness or condition	☐	☐
4. Difficulty with physical exercise	☐	☐
5. Advice from physician not to exercise	☐	☐
6. Recent surgery (last 12 months)	☐	☐
7. Pregnancy (now or within last three months)	☐	☐
8. History of breathing or lung problems	☐	☐
9. Muscle, joint or back disorder, or any previous injury still affecting you	☐	☐
10. Diabetes or thyroid condition	☐	☐
11. Cigarette smoking habit	☐	☐
12. Obesity (more than 20 percent over ideal body weight)	☐	☐
13. Increased blood cholesterol	☐	☐
14. History of heart problems in immediate family	☐	☐
15. Hernia or any condition that may be aggravated by lifting weights	☐	☐

Please explain any "yes" answers on the back. Thank you.

SIGN X _____ DATE: _____