

Medical/Health History for New Clients:

Name: _____

Date: _____

Personal History:

Have you had any of the following conditions? Check all that apply.

- Pain or discomfort in the chest, neck, jaw, arms, or other areas that may result from ischemia
- Shortness of breath while at rest or at mild exertion
- Dizziness or loss of consciousness during exercise
- Sleep apnea
- Ankle edema
- Palpitations or tachycardia
- Intermittent claudication
- Known heart murmur
- Unusual fatigue or shortness of breath with usual activities

Please explain if answered yes to any of the above conditions:

Are you currently taking any medications? Please list all of them below.

	<u>Yes</u>	<u>No</u>
Are you a male ≥ 45 years old, or a female ≥ 55 years old?	<input type="checkbox"/>	<input type="checkbox"/>
Has a first degree relative suffered from myocardial infarction, coronary revascularization, or sudden death before the age of 55 yr. (male) or 65 yr. (female).	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently smoke, or have you quit in the past six months?	<input type="checkbox"/>	<input type="checkbox"/>
Over the past 3 months, have you participated in at least 30 minutes of moderate intensity exercise at least three days each week?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a Body Mass Index ≥ 30 ? If you are unsure, please ask your trainer.	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a blood pressure reading of systolic ≥ 140 mm HG and/or diastolic ≥ 90 mm HG on at least two separate occasions, or are on on antihypertensive medication?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had your cholesterol measured at LDL ≥ 130 , HDL ≤ 40 , or total ≥ 200 ?	<input type="checkbox"/>	<input type="checkbox"/>
Has your HDL cholesterol ever been measured ≥ 60 ?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had your fasting glucose measured at ≥ 100 mg·dL	<input type="checkbox"/>	<input type="checkbox"/>

Personal Habits:

Do you smoke?	Yes	No	Quit
If yes, how much per day? _____			
Do you exercise regularly?	Yes	No	Sometimes
If yes, how often? _____			
Do you consider yourself overweight?	Yes	No	
How many meals do you typically eat per day? _____			
Are you Currently on a diet?	Yes	No	
Do you drink alcohol regularly?	Yes	No	
If yes, how many drinks per week? _____			
Do you consider yourself overly stressed?	Yes	No	
Do you have problems sleeping?	Yes	No	

Have you had any injuries that required rehabilitation or prevented you from participating in activities? If yes, please explain.

Has a physician ever warned you not to participate in physical activity for reasons other than a physical injury? If yes, please explain.

Do you have any additional comments that you think might be pertinent for you personal trainer to know?

All of the above answers will remain confidential between you, your Personal Trainer, and the Personal Training Program Coordinator. However, your medical/health history may be reviewed by Ithaca College Administrators. If you have any questions or problems, please review them with your Personal Trainer or the Program Coordinator.

I have answered all of the above questions about my health history honestly and to the best of my ability and I agree to the confidentiality policy.

X _____ Date: _____