Corvallis Fitness Adventures
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Form Completion Date

Health and Exercise History Form

Name: ______________________________
Address: ____________________________
____________________________________ Gender: Male ❒ Female ❒
Date of Birth: ________________________

Email address ________________ Tel #____________ Cell#________________________
Emergency contact: ____________________ Tel #____________ Relationship:__________
Your physician: ______________________ Tel # ____________Date of last physical:________

Section I

Do you have a history of any of the following cardiac, metabolic, or pulmonary conditions?

HEART/VASCULAR ❒ Y ❒ N
- ❒ diagnosed high blood pressure (or systolic BP >= 140 or diastolic >= 90 mmHG on at least 2 separate checks)
- ❒ coronary angioplasty or cardiac surgery
- ❒ heart disease, heart attack, angina
- ❒ heart murmur
- ❒ peripheral vascular disease
- ❒ stroke
- ❒ other

METABOLIC ❒ Y ❒ N
- ❒ diabetes
- ❒ kidney disease
- ❒ thyroid or other metabolic disorders

RESPIRATORY ❒ Y ❒ N
- ❒ asthma
- ❒ chronic bronchitis
- ❒ emphysema or chronic obstructive pulmonary disease (COPD)
- ❒ other

Do you currently have any of the following signs/symptoms/conditions?

Ankle swelling ❒ Y ❒ N
Chest Pain (at rest or exertion) ❒ Y ❒ N
Dizziness/fainting ❒ Y ❒ N
WOMEN: Are you pregnant? ❒ Y ❒ N

Rapid heartbeats or palpitations ❒ Y ❒ N
Shortness of breath (at mild exertion/rest) ❒ Y ❒ N
Unexplained fatigue (unusual fatigue or shortness of breath with usual activities) ❒ Y ❒ N

If you marked "Y" to one or more of the above, you must obtain your personal physician's consent prior to participating in the exercise and fitness evaluation (see Medical Consultation Form).

Section II

Do you currently have any of the following coronary risk factors?

Female age 55 or above	❐Y	❐N	Smoking habit (within past 6 months)	❐Y	❐N
Male age 45 or above	❐Y	❐N	Family history of heart disease (parents or siblings before age 55)	❐Y	❐N
Hypercholesterolemia/elevated cholesterol or abnormal blood lipids (total cholesterol >= 200 mg/dL or HDL <35 mg/dL)	❐Y	❐N	Sedentary lifestyle (inactive job with no regular exercise/fitness program, active <3x/week, or no recreational pursuits)	❐Y	❐N

If you marked "Y" to any **two or more** of the items in this section, you must obtain your personal physician's consent prior to participating in the exercise and fitness evaluation (see Medical Consultation Form).

Please check if you have any of the following conditions. These conditions may require medical consultation. (Please specify body region if you have arthritis or orthopedic problems.)

❐ MAJOR SURGERY OR HOSPITALIZATION (within the past 6 months)
❐ ANEMIA (severe <10 GM/dl)
❐ ARTHRITIS
❐ CHRONIC BACK PROBLEMS
❐ ORTHOPEDIC PROBLEMS (joint, bone problems)

Please explain: ____________________

What other medical conditions or physical limitations should be considered prior to your participation in an exercise program?

Please specify: ____________________

Please list all drugs (prescription and over-the-counter medications) you are taking:

Drug: __________ Reasons: __________
Drug: __________ Reasons: __________
Drug: __________ Reasons: __________

How many days per week do you have to exercise and how much time for each session?

Please list 2 short term and 2 long term goals that you would like to work on.

I VERIFY THAT I HAVE ANSWERED THESE QUESTIONS TRUTHFULLY AND TO THE BEST OF MY KNOWLEDGE. IF I HAVE A CHANGE IN MY HEALTH STATUS DURING THE COURSE OF MY EXERCISE PROGRAM, I WILL NOTIFY THE EXERCISE AND FITNESS PROFESSIONAL IMMEDIATELY.

Signed: __________ Date: __________

FORM REVIEW:

Date: __________ Changes ❐ Yes ❐ No
If Yes, describe __________