Health History **Name:** _____ **Address:** _____ **e-mail:** _____ **Phone:** _____		
1. Does your physician approve of your participation in this exercise program?	Yes	No
2. Are you taking any medications that affect your vital signs (heart rate, blood pressure, breathing, etc.) or physical performance?	Yes	No
Do you now, or have you had in the past:		
4. History of heart problems in the immediate family?	Yes	No
5. Cigarette, cigar, or pipe smoking habit?	Yes	No
6. Increased blood pressure?	Yes	No
7. Increased total blood cholesterol (>200 mg/dL)	Yes	No
8. Diabetes?	Yes	No
9. History of heart problems, chest pain, or stroke?	Yes	No
10. History of breathing or lung problems?	Yes	No
11. Muscle, joint, or back disorder, or any previous injury still affecting you?	Yes	No
12. Hernia or any condition that may be aggravated by lifting weights?	Yes	No
13. Any chronic illness or condition?	Yes	No
14. Obesity (more than 20% over ideal body weight)?	Yes	No
15. Recent surgery (last 12 months)?	Yes	No
16. Pregnancy (now or within last year)?	Yes	No
17. Difficulty with physical exercise?	Yes	No
18. Advice from physician not to exercise?	Yes	No
Please explain answers below:		

What is your normal daily physical activity level?	
At work:	❑ Light activity (office worker, etc.) ❑ Moderate activity (Nurse, Homemaker, Wait staff, etc.) ❑ Heavy activity (Construction worker, Laborer, etc.)
At home:	❑ Light activity (Walking, watching TV, etc.) ❑ Moderate activity (Weekend sports, or biking, running, playing team sport, or working out in gym, etc., 1-3x per week) ❑ Heavy activity (Strenuous conditioning training, including biking, running, playing team sport, working out in gym, etc. 4-7x per week)