Fitness Health History:

- *Do you have any… Such as…* Known cardiovascular disease? Heart attack, angioplasty, bypass surgery, chest pain (angina), shortness of breath? **Yes No**
- Blood pressure conditions? Are you taking blood pressure medication or under a physician's care for high blood pressure? **Yes No**
- Respiratory disease? Asthma or emphysema **Yes No**
- Vascular disease? Arteriosclerosis (hardening of the arteries), deep vein thrombosis (leg pain, especially when walking)? **Yes No**
- Metabolic disorders? Diabetes type I or II? Thyroid disorder, kidney or liver disease? **Yes No**
- Undiagnosed Chest pain? **Yes No**
- History of back problems? **Yes No**
- Repetitive use syndrome? Tendonitis, carpal tunnel syndrome? **Yes No**
- Orthopedic issues? Broken bones, arthritis, scar tissue that inhibits normal range of motion? **Yes No**
- Mitral valve prolapse? **Yes No**
- Mitral valve stenosis? **Yes No**
- Are you pregnant or post-partum? **Yes No**
- Do you smoke? **Very Little Yes No**
- Are you currently taking any medications or dietary supplements (including vitamins)? **Yes No**
    - If yes, what are you taking? _____
    - Why are you taking it? _____
- Do you currently have an eating disorder, or have you ever had difficulty with an eating disorder? Please explain:

- Have you had surgery within the past two (2) years? Please explain:

- A doctor's approval will be required for some of the "yes" answers. Please indicate if I have your permission to contact your physician to request a release, if required: **Yes No**

Physician's Name _____

Phone Number _____

Participant's Signature _____

Today's Date _____