

Achieve Fitness with Rachel Health History Form

Name: _____ Date: _____

Primary Physician Name: _____ Number: _____

Does your physician know you are/will be participating in an exercise program? Y N

All answers will be treated in a confidential manner.

Coronary Heart Disease Risk

- Family history of heart disease, stroke, vascular disease: prior to age 55 in males, age 65 in females
- Smoke: _____ per day
- High blood pressure (140/90) _____ Months/Years
- Total cholesterol > 200 mg/dl, HDL <40, LDL >130, or triglycerides >150
- Shortness of breath at rest or mild exertion: _____
- Heart murmur or Irregular heart beat: _____
- Frequent chest pains: _____
- Metabolic diseases (thyroid, renal, liver): _____
- Diabetes: _____
- Hypo/Hyperglycemic: _____
- Diet high in sodium, fat, or red meats
- Severe leg pain with movement: _____
- Physically inactive or sedentary lifestyle: _____ Months/Years

General History/Exercise Readiness:

- Epilepsy or seizures: _____
- Current or recent pregnancy: _____
- Recent surgery (within last 12 mo), what type? _____
- Joint injury or joint conditions, what type? _____
- Osteoporosis: _____
- Hernia or other condition, may be aggravated by weight lifting: _____
- History of breathing or lung problems: _____
- Chronic illness or condition: _____
- Fatigue/lack of energy: _____
- Trouble sleeping: _____
- Alcohol: _____ /week: Preference _____
- Caffeine _____ / week: Time of Day _____

Other conditions: _____

Medications: _____

Supplements: _____

The information I have provided is true and complete to the best of my knowledge.

Signature: _____ Date: _____

Guardian signature: _____ Date: _____

