INTERNATIONAL
SPORTS SCIENCES
ASSOCIATION

HEALTH HISTORY QUESTIONNAIRE

Print your answers. Please Print Clearly.		
Name:	Date of Birth:	Age:
Address:		
City, State, Zip:		
Home Phone:	Work Phone:	
Employer:	Occupation:	
In case of emergency, please notify:		
Name:	Relationship:	
Address:		
City, State, Zip:		
Home Phone:	Work Phone:	

Physician Information		
Current Physician:	Phone:	
Are you under the care of a physician, chiropractor, or other health care professional for any reason (circle)? If yes, list reason:	Yes	No
Are you taking any medications? (If yes, please list) Medication: Dosage/Frequency: Condition:	Yes	No
List any and all allergies:		
Has your doctor ever diagnosed you with high blood pressure?	Yes	No
Has your doctor ever diagnosed you with a bone or joint problem that has been or could be made worse by exercise?	Yes	No
Are you over 65 years of age?	Yes	No
Are you used to vigorous exercise?	Yes	No

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MEDICAL INFORMATION - Please answer the following questions (circle one):

1.	Have you experienced any chest pain associated with either exercise or stress?	Yes	No	If yes, please explain:
2.	Have you experienced shortness of breath with or without exercise?	Yes	No	If yes, please explain:
3.	Have you experienced fainting or light-headedness?	Yes	No	If yes, please explain:
4.	Have you had a recent hospitalization for any cause?	Yes	No	If yes, please explain:
5.	Do you have any orthopedic conditions (including arthritis)?	Yes	No	If yes, please explain:
6.	Have you ever experienced a rapid heartbeat or palpitations?	Yes	No	If yes, please explain:
7.	Is there any reason why you should not follow a regular exercise program?	Yes	No	If yes, please explain:

Please indicate if a blood relative (parent, sibling, first cousin, etc.) has a history of any of the following conditions (circle one). If there is family history for any condition, please check the box to the left. On the line to the right, please indicate who in the family has or had this condition.

- ❍ Asthma: _____
- ❍ Respiratory/Pulmonary Conditions: _____
- ❍ Diabetes: Type I: Type II: How Long? _____
- ❍ Epilepsy: Petite Mal: Grand Mal: Other: _____
- ❍ Osteoporosis: _____
- ❍ Coronary Artery Disease: _____
- ❍ Heart Attack: _____
- ❍ Hypertension: _____
- ❍ High Blood Pressure: _____
- ❍ Stroke: _____

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Lifestyle/Habits - Please check the box that describes your current habits:

1. Do you smoke? Yes / No If yes, how often:
   - ❒ Former user; Date quit:
   - ❒ 1 or fewer cigarettes per day
   - ❒ 2 to 5 cigarettes per day
   - ❒ 6 to 10 cigarettes per day
   - ❒ More than 10 cigarettes per day

2. Do you drink caffeine? Yes / No If yes, how often:
   - ❒ Several times a day
   - ❒ Once per day
   - ❒ Few times per week
   - ❒ Few times per month

3. Do you drink alcohol? Yes / No If yes, how often:
   - ❒ Several times a day
   - ❒ Once per day
   - ❒ Few times per week
   - ❒ Few times per month

4. On average, how many hours of sleep do you get each night?
   - ❒ More than 10 hours
   - ❒ 8-10 hours
   - ❒ 5-7 hours
   - ❒ Less than 5 hours

5. On average, what is your energy level like each day?
   - ❒ High energy
   - ❒ Moderate energy
   - ❒ Low energy

Dietary Factors - Please indicate if you (personally) have a history of the following (circle one):

Anemia:	Yes / No
Gastrointestinal Disorder:	Yes / No
Hypoglycemia:	Yes / No
Thyroid Disorder:	Yes / No
Pre/Postnatal:	Yes / No

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Cardiovascular - Please indicate if you (personally) have a history of the following (circle one):

High Blood Pressure:	Yes / No
Hypertension:	Yes / No
High Cholesterol:	Yes / No
Hyperlipidemia:	Yes / No
Heart Disease:	Yes / No
Skipped Heartbeat:	Yes / No
Heart Attack:	Yes / No
Stroke:	Yes / No
Bypass or Cardiac Surgery:	Yes / No
Angina:	Yes / No
Gout:	Yes / No
Phlebitis or Embolism:	Yes / No
Other (please explain):	Yes / No

Please list any other diagnosed conditions and the date of diagnoses below:

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Pain History - Check if you have or have had pain in the following. If yes, please describe:

- ❍ Head/Neck: _____
- ❍ Upper Back: _____
- ❍ Shoulder/Clavicle: _____
- ❍ Arm/Elbow: _____
- ❍ Wrist/Hand: _____
- ❍ Lower Back: _____
- ❍ Hip/Pelvis: _____
- ❍ Thigh/Knee: _____
- ❍ Arthritis: _____
- ❍ Hernia: _____
- ❍ Surgeries: _____
- ❍ Other: _____

Nutrition

Are you on any specific food/diet plan? If yes, please list and advise who prescribed it:	Yes No
Do you take dietary supplements? If yes, please list:	Yes No
Do you notice your weight fluctuating?	Yes No
Have you experienced a recent weight gain or loss? If yes, explain how: Over what amount of time?	Yes No
If you consume caffeine, what types of beverages do you consume that contain caffeine?	
How would you describe your current nutritional behaviors?	
Other food/nutritional issues you want to include *(food allergies, mealtimes, etc.)*	

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Work and Environment

Please check the box that best describes your work and exercise Habits.

- ❍ Intense occupational and recreational effort
- ❍ Moderate occupational and recreational effort
- ❍ Sedentary occupational and intense recreational effort
- ❍ Sedentary occupational and moderate recreational effort
- ❍ Sedentary occupational and light recreational effort
- ❍ Complete lack of activity

How stressful are your environments (circle one)?

Work: Minimal Moderate Average Extremely

Home: Minimal Moderate Average Extremely

Do you work more than 40 hours a week? Yes No

Anything else you would like your personal trainer to know?

PRINTED NAME:

SIGNATURE: DATE:

SIGNATURE OF PARENT:
or GUARDIAN (for participants under the age of 18)

WITNESS:

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