West Village Athletic Club

Health History Questionnaire

Name: _____

Address: _____

Phone: _____

Height: _____' _____ Weight: _____ Age: _____ Date of Birth: _____ /_____ /_____

Doctor: _____ Emergency Contact: _____

Regular physical activity is safe for most people. However, some individuals should check with their doctor before they start an exercise program. To help us determine if you should consult with your doctor before starting to exercise, please read the following questions carefully and answer each one honestly. All information will be kept confidential. Please circle YES or NO:

YES NO Do you have a heart condition?
YES NO Have you ever experienced a stroke?
YES NO Do you have epilepsy?
YES NO Are you pregnant?
YES NO Do you have diabetes?
YES NO Do you have emphysema?
YES NO Do you feel pain in your chest when you exercise?
YES NO Do you have chronic bronchitis?
YES NO In the past month, have you had chest pain when you were not doing physical activity?
YES NO Do you ever lose consciousness or lose control of your balance due to chronic dizziness?
YES NO Are you currently being treated for a bone or joint problem that restricts you from engaging in physical activity?
YES NO Ash a physician ever told you or are you aware that you have high blood pressure?
YES NO Has anyone in your immediate family (parents/brothers/sisters) had a heart attack, stroke or cardiovascular disease before age 55?
YES NO Has a physician ever told you or are you aware that you have a high cholesterol level?
YES NO Do you currently smoke?
YES NO Are you a male over 44 years of age?
YES NO Are you a female over 54 years of age?
YES NO Are you currently exercising LESS than 1 hour per week? If no, please list your activities:

_____

_____

YES NO Are you currently taking any medications? Please list:

_____

What are your fitness goals? Circle all that apply.

Increase strength and endurance	Improve flexibility
Improve cardiovascular fitness	Improve muscle tone
Reduce body fat	Increase muscle mass
Exercise regularly	Injury rehabilitation
Sports Conditioning	Other: _____

What are your specific health goals? Circle all that apply.

Reduce Stress	Improve nutritional habits
Control blood pressure	Control cholesterol
Stop smoking	Achieve balance in life
Improve productivity	Reduce back pain
Feel better all over	Increase health awareness
Other: _____	

I have read, understood, and completed this questionnaire. Any questions that I had were answered to my full satisfaction.

Name: _____ Date: _____ / _____ / _____

Signature: _____