# Health and Fitness Assessment Questionnaire

Name _____ Phone (home) _____ cell_____

Address _____ e-mail _____

Primary Health Care Provider _____ Provider's Phone _____

Birthdate _____

**Health History**

1. Do you smoke? _____ How much? _____
2. Has your doctor ever said your blood pressure was too high or low? _____
3. Have you (or a family member) ever been diagnosed with diabetes? _____
4. Do you have any known cardiovascular problems (abnormal ECG, previous heart attack, atherosclerosis, etc.)? _____

   If so, what? _____
5. Has your doctor ever told you your cholesterol level was high? _____
6. Are you overweight? _____? How much? _____
7. Do you have any injuries or orthopedic problems (bursitis, bad back, bad knees, etc.)?

   _____
8. Are you taking any prescribed medications or dietary supplements? _____
9. Are you pregnant or post-partum less than 6 weeks? _____
10. Date of last physical examination _____
11. Do you have any other medical conditions or problems not previously mentioned? _____

    _____
12. Are you currently involved in a regular exercise program? _____
13. What are your goals within this program? _____

    _____

**Consent Form**

I acknowledge, to the best of my ability, that I am in good health and have no known medical problems that would restrict my ability to participate in this exercise program.

**Signed** _____ **Date** _____

**Witness** _____ **Date** _____