CITY OF BREA
BREA COMMMUNITY CENTER
PERSONAL TRAINING PROGRAM

Health History Questionnaire

Please answer the following questions to the best of your ability. For the following questions, unless otherwise indicated, check (√) the single best choice for each question. As is customary, all of your responses are completely confidential and may only be used in group summaries and/or reports. All information collected is subject to the Privacy Act of 1974. If you have any physical handicaps or limitations that would require special assistance with this questionnaire, please let your trainer know. This form is in accordance with the American College of Sports Medicine guidelines for risk stratification when followed correctly by your trainer.

Name: _____ Height: _____ Weight: _____

Gender: ☐ Male ☐ Female Age: Birth Date: _____

Address: _____

City: _____ State: CA Zip: _____

Home Phone: _____ Work Phone: _____

e-mail: _____

Emergency Contact: _____ Phone: _____

Trainer: _____

Physician: _____ Phone: _____

1. Have you ever had a definite or suspected heart attack or stroke? Yes☐ No☐
2. Have you ever had coronary bypass surgery or any other type of heart surgery? Yes☐ No☐
3. Do you have any other cardiovascular or pulmonary (lung) disease? Yes☐ No☐
   (other than asthma, allergies, or mitral valve prolapse)
4. Do you have a history of: diabetes, thyroid, kidney, and/or liver disease? Yes☐ No☐
   (circle all that apply)
5. Have you ever been told by a health professional that you had an abnormal resting or exercise (treadmill) electrocardiogram (EKG)? Yes☐ No☐
6. If you answered "Yes" to any of Questions 1 through 5, please describe:

7. Do you currently have any of the following:
   a. Pain or discomfort in the chest or surrounding areas that occurs when you engage in physical activity? Yes☐ No☐
   b. Shortness of breath? Yes☐ No☐
   c. Unexplained dizziness or fainting? Yes☐ No☐
   d. Difficulty breathing at night except in upright position? Yes☐ No☐
   e. Swelling of the ankles (recurrent and unrelated to injury? Yes☐ No☐
   f. Heart palpitations (irregular or racing of the heart on more than one occasion? Yes☐ No☐
   g. Pain in legs that cause you to stop walking (claudication)? Yes☐ No☐
   h. Known heart murmur? Yes☐ No☐

   Have you discussed any of the above with your personal physician? Yes☐ No☐
8. Are you pregnant or is it likely that you could be pregnant at this time? Yes☐ No☐
   If yes, what is your expected due date?_____
9. Have you had surgery or been diagnosed with any disease in the past 3 months? Yes☐ No☐
   If yes, please list date _____ and surgery _____.
10. Have you had high blood cholesterol or abnormal lipids within the past 12 months or are you taking medications to control your lipids? Yes☐ No☐
11. Do you currently smoke cigarettes or have quit within the past 6 months? Yes☐ No☐
12. Has your father or brother(s) had heart disease prior to age 65 OR mother or sister(s) had heart disease prior to age 65? Yes☐ No☐
13. Within the past 12 months, has a health professional told you that you have high blood pressure (systolic at/above 140 OR diastolic at/above 90)? Yes☐ No☐
14. Currently, do you have high blood pressure or within the past 12 months, have you taken any medicines to control your blood pressure? Yes☐ No☐
15. Have you ever been told by a health professional that you have a fasting blood glucose greater than or equal to 110 mg/dl? Yes☐ No☐
16. Describe your regular physical activity or exercise program?
    Type:_____ Frequency: _____ days per week.
    Duration:_____minutes. Intensity: (*Check (√) one)* Low ☐ Moderate ☐ High ☐ BMI:_____
17. Which days and times are best for you?_____

    _____
18. If you answered "Yes" to any of questions 7-16, please explain:

    _____

    _____

    _____
19. Are you currently under any treatment for any blood clots? Yes☐ No☐
20. Do you have problems with bones, joints, or muscles that may be aggravated with exercise? Yes☐ No☐
21. Do you have any back or neck problems? Yes☐ No☐
22. Have you been told by a health professional that you should not exercise? Yes☐ No☐
23. Is a physician currently treating you for any other medical condition? Yes☐ No☐
24. Are there any other conditions (mitral valve prolapse, epilepsy, history of rheumatic fever, asthma, cancer, anemia, hepatitis, etc.) that may hinder your ability to exercise? Yes☐ No☐
25. During that past 6 months, have you experienced any unexplained weight loss or gain (greater than 10 pounds for no known reason)? Yes☐ No☐

26. If you have answered "Yes" to any of questions 19-25, please explain: _____

_____

_____

_____

_____

27. Please list below all prescription and over-the-counter medications you are currently taking, including vitamins and supplements:

Medicine	Reason	Dosage	Amount/Frequency

28. Are there any medicines that your physician has prescribed to you in the past 12 months, which you are currently not taking? Yes☐ No☐
If you have answered "Yes" please list: _____

_____

_____

29. Do you follow any special diet at the present time?
If "Yes", which type?
☐ Low cholesterol/low fat ☐ Low salt ☐ Reduced Calorie
☐ Liquid diet ☐ Low carb
☐ Other, please specify _____

30. What are your personal exercise program goals?
☐ Weight control/loss ☐ Staying in shape ☐ Stress reduction
☐ Increase strength ☐ Cardiovascular conditioning
☐ Other, please specify _____

I have answered the Health History Questionnaire questions accurately and completely. I understand that my medical history is a very important factor in the development of my fitness/wellness program. I understand that certain medical or physical conditions, which are known to me, but that I do not disclose to my trainer, may result in serious injury to me. If any of the preceding conditions change, I will immediately inform my trainer of those changes. I, knowingly and willingly, assume all risks of injury resulting from my failure to disclose accurate, complete, and updated information in accordance with the attached questionnaire. I also understand that in order to properly risk stratify my Health History Questionnaire, my trainer should have a minimum of a national certification as a personal trainer. My trainer also verbally explained this statement to me to my understanding.

_____ _____
Client's Signature Date

_____ _____
Trainer's Signature Date

All clients needing written medical clearance from their personal physician must give it to their trainer prior to beginning their exercise program.

Health History Questionnaire follows the American College of Sports Medicine recommendations for risk stratification. This must be performed on all clients in order to determine the need for medical clearance and/or exercise modifications. Any trainer or those making exercise recommendations should be certified in the proper use of the risk stratification process through a national organization.

- **If a client has a "YES" response to anything on Page 1**
  He/she has KNOWN DISEASE, and must have medical clearance prior to beginning exercise.

- **If he/she has a "YES" response to anything on #7 (a-h) on Page 2**
  Your client is HIGH RISK WITH SIGNS/SYMPTOMS and must have medical clearance prior to exercise.

- **If your client has a YES response to #8 or 9**
  He/she must have medical clearance.

- **"YES" responses to two or more on questions #10-16 on Page 2**
  Your client is HIGH RISK WITHOUT SIGNS/SYMPTOMS and must have medical clearance unless he/she also has a "YES" answer to question #7, making them still HIGH RISK WITH SIGNS/SYMPTOMS).