LEGACY
FITNESS & NUTRITION

HEALTH HISTORY QUESTIONNAIRE

Name:	Date of Birth:	Age:
Address:		
City, State, Zip:		
Phone:	Work Phone:	
Email:		
Employer:	Occupation:	
In case of emergency, please notify:		
Name:	Relationship:	
Address:		
City, State, Zip:		
Phone:	Work Phone:	
Email:		

Physician Information	
Current Physician:	Phone:
Are you under the care of a physician, chiropractor, or other health care professional for any reason? If yes, list reason: Yes No	
Are you taking any medications (including supplements and over-the-counter medications)? (If yes, please list) Medication: Dosage/Frequency; Condition Yes No	

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Medical Information – Please answer the following questions:			
List any and all allergies:			
Has a doctor ever diagnosed you with high blood pressure?		Yes	No
Has a 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
Have you experienced any chest pain associated with exercise or stress?	Yes	No	If yes, please explain:
Have you experienced shortness of breath with or without exercise?	Yes	No	If yes, please explain:
Have you ever experienced fainting or light-headedness?	Yes	No	If yes, please explain:
Have you had a recent hospitalization for any cause?	Yes	No	If yes, please explain:
Do you have any orthopedic conditions (including arthritis)?	Yes	No	If yes, please explain:
Have you ever experienced a rapid heartbeat or palpitations?	Yes	No	If yes, please explain:
Is there any reason why you should not follow a regular exercise program?	Yes	No	If yes, please explain:

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Please indicate if a blood relative (parent, sibling, first cousin, etc.) has a history of any of the following conditions. If there is family history from 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 Heart Disease:	_____
❑ Heart Attack:	_____
❑ Hypertension (High Blood Pressure):	_____
❑ Stroke	_____

Lifestyle/Habits – Please check the box that describes your current habits:			
1. Do you smoke? ❑ 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	Yes	No	If yes, how often:
2. Do you drink alcohol? ❑ Several times a day ❑ Once per day ❑ Few times per week ❑ Few times per month	Yes	No	If yes, how often:
3. Do you drink caffeine? ❑ Several times a day ❑ Once per day ❑ Few times per week ❑ Few times per month	Yes	No	If yes, how often:
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			
On average, what is your energy level like each day? ❑ High energy ❑ Moderate energy ❑ Low energy			

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Cardiovascular – Please indicate if you (personally) have a history of the following:		
Hypertension (High Blood Pressure)	Yes	No
High Cholesterol (including triglycerides)	Yes	No
Heart Disease	Yes	No
Heart Palpitations	Yes	No
Heart Attack	Yes	No
Stoke	Yes	No
Bypass or Cardiac Surgery	Yes	No
Angina (Chest Pain)	Yes	No
Gout	Yes	No
Phlebitis or Embolism (Blood clots)	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	_____

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

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How stressful are your environments?

Work:	Minimal	Moderate	Average	Extremely
Home:	Minimal	Moderate	Average	Extremely

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

Nutrition and Dietary Factors

Please indicate if you (personally) have a history of the following:

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

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

Have you experienced a recent weight gain or loss?
If yes, explain how:
Yes No
Over what period of time?

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, meal times, etc...)?

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Anything else you'd like your personal trainer / coach to know?

I certify that the information provided is accurate to the best of my knowledge. I understand that Legacy Fitness & Nutrition, LLC is not a medical provider or dietician, and I agree to consult a physician before starting any fitness or nutrition program if I have concerns about my health.

_____

Printed Name

_____

Signature **Date**

_____

Signature of parent/guardian (for participants under the age of 18)

_____

Witness