# MEDICAL HISTORY

**Client Name (Please Print)** _____ **Date of Birth** _____

**SECTION 1 – Please check all conditions that you have had or are currently receiving treatment for.**

☐ Recent Illness, Hospitalization or Surgical Procedure [Please Detail Below any within the last two years.]

_____

_____

☐ 65 Years of Age or Older ☐ Obesity (BMI ≥ than 30) [HEIGHT _____] [WEIGHT _____] [BMI _____]

☐ Borderline or High Cholesterol
*(Total serum cholesterol >200 mg/dL; HDL<35 mg/dL; LDL>130 mg/dL or total cholesterol to HDL ratio >5)*

☐ Abnormal Resting or Stress ECG

☐ Chest Pain at Rest or Exertion

☐ Diabetes

☐ Phlebitis (Deep Vein Thrombophlebitis)

☐ Orthopedic Problems (Arthritis or any other Bone, Joint or Muscle Problems)

☐ Rheumatic Fever

☐ Heart Attack, Coronary Bypass, Cardiac Surgery or Stroke

☐ Pulmonary Disease (Asthma, Emphysema and Bronchitis)

☐ High Blood Pressure (≥ than 140 mmHg over 90 mmHg)

☐ Uneven, Irregular, or Skipped Heart Beats (including a Racing or Fluttering Heart)

☐ Light Headedness, Fainting or Seizures

☐ Unusual Shortness of Breath

☐ Do you know of <u>any other reason</u> why you should restrict or not participate in physical activity?

_____

_____

**SECTION 2 – Please check all conditions that you have had or are currently receiving treatment for.**

☐ Current Medications [please List] _____

☐ Drug Allergies [please List] _____

☐ Emotional Disorders [please List] _____

☐ Family history of coronary or other atherosclerotic disease prior to age 55 male/65 female

☐ Male over age of 44 or Female over age of 54 ☐ Physical Inactivity ☐ Smoker

# MEDICAL HISTORY

**By signing below, I confirm that the provided information is true, complete and accurate to the best of my knowledge.**

| | |
|---|---|
| Client Name (Please Print) | Client Signature |
| Parent/Guardian Name (for minors) | Parent/Guardian Signature |
| Emergency Contact (Please Print) | Emergency Contact Phone Number |

NOTE: You may be able to do any activity you want – as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice. This physical activity clearance may become invalid if your condition changes.

**YOU MUST NOTIFY YOUR TRAINER OF ANY CHANGES IN YOUR HEALTH STATUS OR MEDICAL CONDITION.**

PRIVACY: The information provided on this form will be used as an aid to provide proper personal training guidance while you are a client of a House of Fundamentals. This information will not be released without your prior knowledge and consent.

## FOR TRAINER'S USE ONLY

### Recommendations / Health Status Classification

**If YES** to (one) or more questions from SECTION 1 *or* (two) or more questions from SECTION 2, client must get a PHYSICIAN'S APPROVAL and sign a WAIVER before beginning personal training program.

**If NO** to all questions in SECTION 1 and 2, client can begin an exercise program.

- ☐ ***Client MAY BEGIN a personal training program.***
- ☐ ***DELAY training program because of temporary illness such as cold or fever.***
- ☐ ***DELAY training because client either is or may be pregnant. Client must talk to their doctor before becoming more active.***
- ☐ ***Client must receive PHYSICIAN'S APPROVAL and sign a WAIVER before beginning personal training program.***
- ☐ ***UNABLE TO TRAIN. Client should work with a doctor or physical therapist on a medically supervised exercise program.***

| | |
|---|---|
| Trainer | Today's Date |