Fit For Life

Health History Questionnaire

Name_____ **Date**_____
Address_____
E-mail_____
Phone _____ **Date of Birth**_____
Occupation_____

Date of last physical examination_____

Please circle any of the following that apply to you or your immediate family.

High Blood Pressure
Heart Disease
High Cholesterol/Lipids
Smoker
Heart attack
Diabetes
Stroke
Very Stressed

Explain_____
_____
_____

Please circle any that may apply to you past or present.

Allergies
Asthma
Abnormal Heart Rhythms
Orthopedic Problems (Back, Knee, Shoulder, etc.)
Shortness of breath/chest pain during rest/exertion
Arthritis/Tendonitis/Bursitis
Fainting Spells
Thyroid disease

Please explain_____
_____
_____

Are you presently being treated by a physician or taking medication? **Please explain.**
_____
_____
_____-