

**FITNESS CONSULTING, INC.**

**MEDICAL QUESTIONNAIRE**

NAME \_\_\_\_\_ DATE \_\_\_\_\_ E-MAIL \_\_\_\_\_

ADDRESS \_\_\_\_\_ DOB \_\_\_\_\_

HOME PH # \_\_\_\_\_ WORK # \_\_\_\_\_ CELL # \_\_\_\_\_

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**(1)** Have you had or do you have any of the following? (Please check if Yes)

- |                                                |                                               |                                              |
|------------------------------------------------|-----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Anemia               | <input type="checkbox"/> Aneurysm            |
| <input type="checkbox"/> Heart Attack/Disease* | <input type="checkbox"/> Angina/Chest Pain    | <input type="checkbox"/> Diabetes*           |
| <input type="checkbox"/> High Cholesterol*     | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Abnormal EKG        |
| <input type="checkbox"/> High Blood Pressure*  | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Rapid Heart Beat     | <input type="checkbox"/> Disease of Arteries |
| <input type="checkbox"/> Varicose Veins        | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Fibromyalgia        |
| <input type="checkbox"/> Lyme Disease          | <input type="checkbox"/> Lupus                | Other: _____                                 |

**(2)** Do you have any of the following that may limit your exercise?

- |                                            |                                            |                                            |
|--------------------------------------------|--------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Hip/Pelvis Injury | <input type="checkbox"/> Shoulder Injury   |
| <input type="checkbox"/> Bone Fracture     | <input type="checkbox"/> Knee Injury       | <input type="checkbox"/> Tennis Elbow      |
| <input type="checkbox"/> Ankle/Foot Injury | <input type="checkbox"/> Back Injury       | <input type="checkbox"/> Wrist/Hand Injury |
| <input type="checkbox"/> Calcium Deposits  | <input type="checkbox"/> Nerve Damage      | <input type="checkbox"/> Head/Neck Injury  |

Details: \_\_\_\_\_

\_\_\_\_\_

**(3)** Have any of your relatives ever had any of the following?

- |                                               |                                              |                                           |
|-----------------------------------------------|----------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Diabetes Mellitus    | <input type="checkbox"/> Heart Operations    | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Heart Attack/Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke           |

If yes, note the relationship and age: \_\_\_\_\_

**(4)** Has your physician ever advised you against exercise? ( ) YES ( ) NO

Name of your physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

**(5)** Are you currently receiving Physical Therapy? ( ) YES ( ) NO

**(6)** Are you presently taking any medications? ( ) YES ( ) NO

If yes, please list names and dosages: \_\_\_\_\_

**(7)** Are you currently on a specific diet? ( ) YES ( ) NO

If yes, please explain: \_\_\_\_\_

**(8)** Do you smoke? ( ) YES ( ) NO

If yes, at what age did you start? \_\_\_\_\_ If you stopped, date you quit: \_\_\_\_\_

**(9)** When exercising, including stair climbing, do you ever experience any:

\_\_\_ Chest Pain                      \_\_\_ Dizziness                      \_\_\_ Shortness of Breath  
\_\_\_ Chest Pressure                \_\_\_ Leg Pains                      \_\_\_ Unusual Fatigue

If so, how often:    ( ) Rarely                      ( ) Occasionally                      ( ) Often                      ( ) Always

**(10)** How would you rate the stress level of your job?

( ) Very Little            ( ) Somewhat            ( ) Moderate            ( ) Heavy

**(11)** How would you rate the amount of physical activity at work?

( ) Very Little    ( ) Little            ( ) Moderate            ( ) Active            ( ) Very Active

**(12)** Are you currently involved in an exercise program?            ( ) YES            ( ) NO

Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(13)** What are your personal fitness goals?

\_\_\_ Weight Control/Loss            \_\_\_ Stress Reduction            \_\_\_ Cardiovascular Conditioning  
\_\_\_ Increase Strength            \_\_\_ Lower Blood Pressure            \_\_\_ Rehabilitation  
\_\_\_ Muscle Toning            \_\_\_ Lower Cholesterol            \_\_\_ Other: \_\_\_\_\_

**(14)** Which of the following activities are you interested in?

\_\_\_ Walking                      \_\_\_ Hiking                      \_\_\_ Weight Training                      \_\_\_ Golf  
\_\_\_ Step/Aerobics            \_\_\_ Bicycling/Spin            \_\_\_ Tennis                      \_\_\_ Jogging  
\_\_\_ Martial Arts            \_\_\_ Swimming                      \_\_\_ Skiing                      \_\_\_ Other: \_\_\_\_\_

**(15)** Have you ever had a stress test?                      ( ) YES                      ( ) NO

If yes, please note date and explain results: \_\_\_\_\_

**(16)** Date of last physical examination: \_\_\_\_\_

**(17)** Please list any hospitalizations, including dates and reasons for stay: \_\_\_\_\_  
\_\_\_\_\_

**(18)** Any other medical concerns not previously mentioned? \_\_\_\_\_  
\_\_\_\_\_

I certify that the responses given herein are true and complete to the best of my knowledge. I hereby acknowledge that the use of the facilities of, or any training sessions or exercise classes offered by Fitness Consulting, Inc. will necessarily require physical and mental exertion and hereby assume the risk of any injury or damage to person or property resulting from or in connection with the use by me or my guests of any of the facilities, classes, or equipment provided by Fitness Consulting, Inc., and hereby release Fitness Consulting, Inc., its owners, affiliates, agents, partners, employees, representatives, subcontractors, and insurers, and agree to defend, indemnify and hold them harmless of and from any claim, demand, action, or cause of action for injury, damage or loss to person or property asserted by or occurring in favor of me or any of my guests.

Signature \_\_\_\_\_