Health and Fitness Medical History Questionnaire
Forte Counseling and Wellness Center - Fitness Services

Name: ____ Date: _____________________

Age: ____________ Date of birth: ______________________ Phone: ________________________

Address: ____

E-mail: ____________________________ ____

Primary Health Care Provider: ____

Phone: _____________________________________

Permission to contact: _______ Yes ________ No

Other healthcare specialists: ____

Phone: _____________________________________

Permission to contact: _______ Yes _________ No

Health history:

1. Do you smoke? _________ Yes ________ No ; If yes, for how long? __________ Have you ever

   tried to or wanted to quit? ________ Yes ________ No ; Have you ever had any lung or breathing problems like asthma or emphysema? _______ Yes ________ No

2. Do you have high blood pressure? _________ Yes _________ No; If yes, for how long? ______

   What medications do you take for it? ____

3. Have you or a family member been diagnosed with diabetes? _______ Yes _______ No; If yes,

   how long ago? _________ Medications: ____

4. Do you have any known cardiovascular problems or vascular problems (i.e. heart disease, prior heart attacks, EKG irregularities, atherosclerosis, strokes, etc.)? _______ Yes ________ No

   If yes, which ones and when? ____

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5. Do you have high cholesterol? _______ Yes _______ No; If yes, medications?
   ____

6. Have you ever been diagnosed with or treated for thyroid problems? ______ Yes ______ No

   If yes, medications: ____

7. Are you overweight? _______ Yes ________ No; If yes, by how much? __________ What have

   you tried to lose weight in the past? ____

8. Have you ever had any significant injuries or orthopedic problems? ______ Yes ______ No; If yes, what kind and where? ____

9. Are you pregnant or recently post-partum? _______ Yes ________ No
   If yes, how far along are you or when was your most recent date of birth? _________________

10. What medications and/or supplements are you taking? __________________________________
    ____
    ____
    ____
    ____

11. Please list any other medical conditions or problems that you have been diagnosed with?
    ____
    ____
    ____
    ____
    ____

12. Do you have any allergies (including to medications)? _______ Yes ______ No ; If yes, to what?
    ____
    ____

13. Do you have any stomach problems? ________ Yes ________ No; If yes, what kind?
    ____
    Medications: ____

14. Have you ever been diagnosed with cancer? _______ Yes _______ No; If yes, what kind and when?
    ____
    ____

15. Describe your current exercise routine:

16. Has the doctor given you any physical limitations for exercise? _______ Yes _______ No; If yes, what are the limitations?

____
____

17. What are your goals for an exercise or fitness program?
_1____
_2____
_3____

I acknowledge that the above information is correct, to the best of my knowledge, and that I am in generally good health with no known current health problems that would restrict my ability to safely participate in an exercise program. By signing this form, I acknowledge that I have medical clearing to participate in an exercise program.

Signed: ____ Date: _________________