Medical History

Name ________________________Date __________ Physician's Name _____________________
Address ______________________________________ City ___________ State _____ Zip ______
Home Phone # ______________________ Cell Phone # ________________________
Age ________ Weight _______ Height _______ Sex: ☐ Male ☐ Female

Person to contact in case of emergency:
Name _________________ Relationship ________________ Phone # _____________________

Describe you current exercise habits / program:

Mode: ______________________ Intensity: _____________________
Duration: _______________________ Frequency: ____________________
Progression: _______________________

How long have you participating in this program?

Does your physician know that you are participating in the above program?
Yes No
☐ ☐

Does you physician know that you are planning on participating in activities with Framework Personal Training?
Yes No
☐ ☐

How often would you characterize your stress level as being high?
☐ Occasionally ☐ Frequently ☐ Constantly

Please list your current recreational interests: ____
____
____
____
____

Do you have now, or have you had in the past:

Yes No

☐ ☐ 1. Cardiovascular Disease - myocardial infarction, angioplasty, cardiac surgery, coronary artery disease, angina, and/or hypertension: If so, which?
____

☐ ☐ 2. Pulmonary Disease - asthma, emphysema, and /or bronchitis. If so, which?___________________________________

☐ ☐ 3. Cerebrovascular Disease - stroke, etc. If so, which?
____

☐ ☐ 4. Diabetes

☐ ☐ 5. Peripheral Vascular Disease

☐ ☐ 6. Anemia

☐ ☐ 7. Phlebitis

☐ ☐ 8. Cancer

☐ ☐ 9. Pregnancy

☐ ☐ 10. Osteoporosis

☐ ☐ 11. Emotional Disorders

☐ ☐ 12. Eating Disorders

Have you had any of the following physical examination findings?

Yes No

☐ ☐ 13. Murmurs, clicks or other abnormal heart sounds

☐ ☐ 14. Abnormal blood lipids and lipoproteins

☐ ☐ 15. High Blood Pressure

☐ ☐ 16. Edema

☐ ☐ 17. Irregular ECG or EEG

Have you experienced any of the following especially associated with activity, eating a large meal, emotional distress, or exposure to cold?

Yes No

☐ ☐ 18. Discomfort: pressure, tingling, pain, heaviness, burning or numbness in chest, jaw,
☐ ☐ neck or arms?

☐ ☐ 19. Lightheadedness, dizziness, or fainting

☐ ☐ 20. Shortness of breath

☐ ☐ 21. Rapid heart beats or palpitations

Have you recently been ill, hospitalized, or had surgery?

Yes No

☐ ☐ 22. If yes, please explain: ____

☐ ☐ 23. Arthritis

☐ ☐ 24. Joint Swelling

☐ ☐ 25. Any orthopedic surgery of any kind? Please specify:____________________________

Do you use any medications or have drug allergies?

Yes No

☐ ☐ 26. If yes, please list and specify: ____

Other habits:
Yes No
☐ ☐ 27. Caffeine, tobacco, or recreational drug use? f yes, please list and specify:

____

28. Have you been told by a physician or other health technician that you are obese?
Yes No
☐ ☐

29. Do you now or have you ever had a hernia or any other conditions that may be aggravated by lifting weights?

Do you have a family history of any serious illness, disease, condition or disorder such as heart disease, cancer lung problems, diabetes, high blood pressure or cholesterol, orthopedic problems, etc.? If yes, please list and specify family relation.

____
____
____

Are there any other conditions or health matters not discussed above that you would like Framework to be aware of prior to you participation in any activities?

____
____

By signing and dating below, I do hereby acknowledge that I am responsible for the full disclosure of any information that is requested on this form and the information I have provided in this Health History Questionnaire is true and complete to the best of my knowledge. I have been instructed to update this health history questionnaire as changes in my health status occur.

____
Signature of Participant Date

____
Signature of Trainer or Technician Date