BIG DAWG FITNESS TRAINING

Health History Questionnaire

Name: _____ Date of Birth _____ Age _____

Cell Phone _____ Height: _____ Weight: _____

In case of emergency, please notify

Name _____ Relationship _____

Home Phone _____ Cell Phone _____

Medical Information

Are you under the care of a physician, chiropractor or other health care professional? Yes ☐ No ☐

If so, Please explain

Physician Name: _____

Date of Last Physical Exam: _____

List all medications

Medication Type	Purpose of Medication	Length of medication use?

Allergies _____

Important Surgeries

Do you use any assistive devices: _____

Check All medical conditions that apply to you.

Heart Attack ☐	High Blood Pressure ☐	Heart Disease ☐	High Cholesterol ☐
Asthma ☐	Breathing Problems ☐	Persistent Coughs ☐	Muscle pulls/strains ☐
Hernia ☐	Osteoporosis ☐	Back or Neck Injuries ☐	Bone or Joint Issues ☐
Stroke ☐	Epilepsy/Seizures ☐	Dizziness/Fainting ☐	Blackouts ☐
Headaches ☐	Diabetes ☐	Thyroid ☐	Bladder ☐
Kidney ☐	Pneumonia ☐	Frequent Colds ☐	Nausea ☐
Cancer ☐	Are you pregnant ☐	Over 65 ☐	Other ☐

Explain

Lifestyle Information

What are you fitness goals?

How would you describe your diet plan?

Do you have any special dietary issues? Yes ☐ No ☐
Are you on a low or restricted calorie diet? Yes ☐ No ☐

Explain

Have you had any recent weight loss or gain? Yes ☐ No ☐
Are you unaccustomed to vigorous exercise? Yes ☐ No ☐

Describe you current level of exercise.

Do you have chest pains from exercise or stress? Yes ☐ No ☐

Explain

Do you smoke? Yes ☐ No ☐ How much? _____
Do you drink alcohol? Yes ☐ No ☐ How much? _____
How much water do you drink daily? _____

Degree of Environmental Stress Low ☐ Moderate ☐ Average ☐ High ☐

Please make any other comments you feel are pertinent to your exercise program.

Client Signature: _____ Date: _____

Clear Form Print