SISTERS ATHLETIC CLUB

Health History Questionnaire

Name_____ Date_____ /_____ / _____
Mailing Address_____ City, State, Zip_____
email _____ @ _____
Telephone #_____-_____-_____ Alternate Telephone #_____-_____-_____
Approximate Height_____ Approximate Weight_____
Birth date_____ /_____ / _____ Age_____ Blood Pressure_____/_____ (est. or actual)
Emergency contact person and telephone #_____

Regular physical activity is safe for most people. However, some individuals should check with their doctor before they start an exercise program. To help us determine if you should consult with your doctor before starting to exercise at the Sisters Athletic Club, please read the following questions carefully and answer each one honestly. All information will be kept confidential. Please check yes or no. Use the back for additional information if needed.

Yes	No	
☐	☐	Do you have, or have you ever had a heart condition?
		If yes, please explain_____
☐	☐	Have you ever experienced a stroke?
☐	☐	Do you have epilepsy?
☐	☐	Are you Pregnant?
☐	☐	Do you have Diabetes?
☐	☐	Do you have emphysema?
☐	☐	Do you have, or have you ever had pain in your chest while exercising?
☐	☐	In the past month, have you ever had chest pain when you were not doing physical activity?
☐	☐	Do you have chronic bronchitis?
☐	☐	Do you ever lose consciousness or do you ever lose control of your balance due to dizziness?
☐	☐	Has a physician ever told you, or are you aware that you have high blood pressure?
☐	☐	Has anyone in your immediate family had a heart attack, stroke or heart disease before age 55?
☐	☐	Has a physician ever told you, or are you aware that you have high cholesterol?
☐	☐	Do you currently smoke?
☐	☐	Have you ever smoked consistently?
☐	☐	Are you currently being treated for any bone or joint problem that restricts you from engaging in physical activity? If yes, please explain_____
☐	☐	Are you currently exercising less than 1 hour per week?
☐	☐	Are you currently taking any medications? If yes, please explain_____
☐	☐	Have you had any surgeries in the past 6 months? If yes, please explain_____
☐	☐	Do you have any reason to believe that you should <u>not</u> exercise? If yes, please explain_____

Is it OK to contact your physician if we deem appropriate?_____ Physician's name_____

I have completed this questionnaire honestly and with full understanding.

Signature_____ Date_____ /_____ / _____

Cleared to exercise? _____ If no, reason_____
Staff Name_____Signature_____Date_____