

Health History for The Total Training Company

Name _____

Date _____

Date of Birth ____/____/____

Has your doctor ever said you have heart trouble?	Yes ___	No ___
Do you frequently have chest pain?	Yes ___	No ___
Do you experience shortness of breath?	Yes ___	No ___
Do you often feel faint or have spells of dizziness?	Yes ___	No ___
Do you have a heart murmur?	Yes ___	No ___
Do you experience weakness in the legs?	Yes ___	No ___
Has a close family member had heart disease or a heart attack prior to age 55?	Yes ___	No ___
Do you have high blood pressure?	Yes ___	No ___
Do you have high cholesterol?	Yes ___	No ___
Do you have diabetes?	Yes ___	No ___
Do you smoke?	Yes ___	No ___
Are you taking any medications or drugs that may alter your response to exercise?	Yes ___	No ___
Do you have any orthopedic (bones and/or muscles) conditions that could be aggravated by exercise?	Yes ___	No ___
For women – Are you pregnant?	Yes ___	No ___
Is there any reason why you should not participate in an exercise program?	Yes ___	No ___

I, _____, certify the health history and other information I have provided is complete and accurate to the best of my knowledge, and agree to inform **The Total Training Company** of any change in my health or medical status.

Signature

Date