Pavilion Fitness
Health History Questionnaire

www.pavilionfitness.com

Name_____

Home Address_____

Telephone (home)_____ (work)_____

Height_____ Weight_____

Gender_____ Birth date_____ Age_____

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 with Pavilion Fitness, please read the following questions carefully and answer each one honestly. All information will be kept confidential.

YES NO **Section I**

One or more "YES" needs medical release

YES	NO		
☐	☐	1.	Do you have a heart condition?
☐	☐	2.	Have you ever experienced a stroke?
☐	☐	3.	Do you have epilepsy?
☐	☐	4.	Are you pregnant?
☐	☐	5.	Do you have diabetes?
☐	☐	6.	Do you have emphysema?
☐	☐	7.	Do you have chronic bronchitis?
☐	☐	8.	Have you had a graded treadmill test/stress test prescribed by a doctor in the past 12 months?
☐	☐	9.	In the past 12 months, has a physician ever told you or are you aware that you have high blood pressure?

YES NO **Section II**

Three or more "YES" needs medical release

YES	NO		
☐	☐	10.	Do you feel pain in your chest when you engage in physical activity?
☐	☐	11.	In the past month, have you had chest pain when you were not doing physical activity?
☐	☐	12.	Do you ever lose consciousness or do you ever lose control of your balance due to chronic dizziness?
☐	☐	13.	Are you currently being treated for a bone or joint problem that restricts you from engaging in physical activity?
☐	☐	14.	Has anyone in your immediate family (parents/brothers/sisters) had a heart attack, stroke, or cardiovascular disease before age 55?
☐	☐	15.	Has a physician ever told you or are you aware that you have high cholesterol level?
☐	☐	16.	Do you currently smoke?
☐	☐	17.	Are you a male over 44 years of age?

YES	NO		
☐	☐	18.	Are you a female over 54 years of age?
☐	☐	19.	Are you currently exercising *LESS* than 1 hour per week? If you answered no, please list your activities.
☐	☐	20.	Any other medical conditions? *(Surgical procedures, injuries, etc…)* If yes, please list below:

_____

_____

_____

Medications

Section III

Do you take any of the following medications? *(Doctor Prescribed)*

For the *Heart* YES NO
If YES, what type?_____

For *High Blood Pressure* YES NO
If YES, what type?_____

For *High Cholesterol* YES NO
If YES, what is your Total Blood Cholesterol?_____

For *Diabetes* YES NO
If YES, what type?_____

For *Stroke* YES NO
If YES, what type?_____

Are you currently taking any other medications?

Medication	Purpose

I understand that any exercise program I undertake may create physical stress and subsequent harmful effects. I agree that it is solely my responsibility and not the responsibility of Pavilion Fitness to require me to consult with a physician prior to commencing any exercise program, to remain under medical supervision if that is indicated, and to seek medical assistance in the event of an injury. I recognize that the use of equipment entails some risk of accidental injury to myself and to others and I agree that I will use such equipment and facilities with due care. I have read, understood, and completed this questionnaire. Any questions that I had were answered to my full satisfaction.

Name_____ Date_____

Signature_____

Staff Use Only

Cleared to Exercise ☐

Not Cleared to Exercise/ Needs *Medical Release* ☐

[Section I] [Section II] [Section III]

Staff Signature_____

Date_____

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