International Sports Sciences Association





Answer Each Question By Printing The Necessary Information. Your Answers Are Confidential Name: Date of Birth: Age: Address: City, State, Zip: Home Phone: Work Phone: Employer: Occupation: In case of emergency, please notify: Name: Relationship: Address: City, State, Zip: Home Phone: Work Phone: MEDICAL INFORMATION Physician: Phone: Are you under the care of a physician, chiropractor, or other health care professional for any reason?

Yes □ No If yes, list reason: Are you taking any medications? ☐ Yes □ No (If yes, complete the following) Type: Dosage/Frequency: Reason for Taking: Please list any allergies: ☐ Yes Has your doctor ever said your blood pressure was too high? □ No ☐ Yes Has your doctor ever told you that you have a bone or joint □ No problem that has been or could be made worse by exercise? ☐ Yes □ No Are you over the age of 65? Are you unaccustomed to vigorous exercise? ☐ Yes O No

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> Health History Questionnaire

MEDICAL INFORMA	TION, CONTINUED							
Is there any reason no If yes, please explain:	t mentioned why yo	ou should not follow a regular	exercise program?	□ Yes □ N				
Have you recently exp	erienced any chest	pain associated with either ex	ercise or stress?	☐ Yes ☐ N				
If yes, please explain:		,						
SMOKING								
Please check the box t	hat describes your	current habits:						
		e quit:	_					
☐ Cigar and,	or pipe cigarettes per day							
☐ 16 to 25 d	igarettes per day							
	☐ 26 to 35 cigarettes per day ☐ More than 35 cigarettes per day							
	- 33 cigarettes per e	nuy						
FAMILY AND PERSO	ONAL M EDICAL I	History						
tions fill the informati	on in on the line to	the right		experiencing any of these condi-				
☐ Asthma:	- E- E- 200	the right.						
☐ Respirator	y/Pulmonary Condi	tions:						
☐ Diabetes:	Type I:	Type II:	How Long?					
☐ Epilepsy:	Petite Mal:	Grand Mal:	Other:					
☐ Osteoporo	osis:							
LIFESTYLE AND DIE	TARY FACTORS							
Please fill in the inform	nation below:							
☐ Occupatio	nal Stress Level:	☐ Low / ☐ Medium / ☐ Hi	gh					
☐ Energy Lev		☐ Low / ☐ Medium / ☐ Hi						
☐ Caffeine Ir	ntake/Daily:	_ □ Alcohol Intake/Weekly:_						
☐ Colds Per	Year:	☐ Anemia:						
☐ Gastrointe	estinal Disorder:							
☐ Hypoglyce	emia:							
☐ Thyroid D	isorder:							
□ Pre/Postna	atal:							
CARDIOVASCULAR								
Please fill in the inform	nation below:							
☐ High Bloo	d Pressure:	⊐ Hype	ertension:	Walter Street Street				
☐ High Chol	lesterol:		5-1-1-6	120 1 2 2 1 1 1 1 1 2 2				
☐ Hyperlipid	lemia:							
☐ Heart Dise	ease:							
☐ Heart Dise	ease:							
☐ Heart Atta	ick:		e:					
☐ Angina:		☐ Gout	i					

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> Health History Questionnaire

FAMILY AND PERSONAL MEDICAL HISTORY, CONTINUED

Musculoskeletal Information		
Please describe any past or current musculoskeletal conditions you have incurred such as muscle pull back pain, or general discomfort:	s, sprains, frac	tures, surgery,
☐ Head/Neck:	April to division in .	Market Comment
☐ Upper Back:	CHOUNCE: LAN	CHE
☐ Shoulder/Clavicle:	KENTER DAG	o pendidir.
☐ Arm/Elbow:		100 2.11
☐ Wrist/Hand:	Sale T.	personal firm
☐ Lower Back:	beef T	The target of the
☐ Hip/Pelvis:		
☐ Thigh/Knee:		
☐ Arthritis:	r thy come	otheyen son Fra
☐ Hernia:		
☐ Surgeries:		
☐ Other:		
NUTRITIONAL INFORMATION		1 7 1 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Are you on any specific food/diet plan at this time? If yes, please list:	☐ Yes	□ No
Do you take dietary supplements? If yes, please list:	☐ Yes	□ No
Do you experience any frequent weight fluctuations?	☐ Yes	□ No
Have you experienced a recent weight gain or loss? If yes, list change:	☐ Yes	□ No
Over how long?		
How many beverages do you consume per day that contain caffeine?		
How would you describe your current nutritional habits?		
Other food/nutritional issues you want to include (food allergies, mealtimes, etc.)		

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Work	AND EXERC	ISE HABITS			in an experience of the Contract of the contra	
Please o		nat best describes you		ercise Habits.		
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	☐ Sedentary of	occupational and moccupational and lig ack of all exertion				Labor regula (C. Barat Trabili (1837)
To what	t degree do you	perceive your envi	ronment as stress	sful?		See Cords
Work:	☐ Minimal	☐ Moderate	☐ Average	☐ Extremely		al and the C
Home:	☐ Minimal	☐ Moderate	☐ Average	☐ Extremely		The section of the se
Do you	work more than	1 40 hours a week?			☐ Yes	□ No
Please n	nake any other	comments you feel	are pertinent to	your exercise progra	im.	
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AME: _						
IGNATU	RE:			,	DATE:	
GNATUR	RE OF PARENT:	s under the age of major			WITNESS:	