FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Form I
Health History

Name_____ Date_____

Age_____ DOB_____ Sex ☐ M ☐ F

Physician's name_____

Physician's Phone_____

Person to contact in case of emergency:

Name_____ Relation_____ Phone_____

Are you taking any medication or drugs? Include: vitamins and herbal supplements (please list medication, dose and reason)_____

_____

_____

Do you now or have had in the past:	Yes	No
1. History of heart problems, chest pain or stroke	☐	☐
2. Increased blood pressure	☐	☐
3. Any chronic illness or condition	☐	☐
4. Difficulty with physical exercise	☐	☐
5. Advice from physician not to exercise	☐	☐
6. Recent surgery (last 12 months)	☐	☐
7. Pregnancy (now or within last 3 months)	☐	☐
8. History of breathing or lung problems	☐	☐
9. Muscle, joint or back disorder, or any previous injury still affecting you	☐	☐
10. Diabetes or thyroid condition	☐	☐
11. Cigarette Smoking Habit (ppd_____)	☐	☐
12. Obesity (More than 20 percent over ideal body weight)	☐	☐
13. Increased blood cholesterol	☐	☐
14. History of heart problems in immediate family	☐	☐
15. Hernia, or any condition that may be aggravated by lifting weights	☐	☐

Please explain any "yes" answers on the back

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