HEALTH INFO FORM

1. PERSONAL DETAILS:

Name & Surname: ____

Address: ____

Phone: (w) ___________________________________ (cell) ____

Name and number of family member in case of emergency: ____

Birth Date: ___________________________________ Age: ____

2. MEDICAL HISTORY:

How long since your last medical check-up:____

Details of your regular Doctor: ____

Are you taking any prescribed medication? If yes, list below:

____

____

Has anyone in your family suffered from heart disease? If yes, which relative and their age:

____

Have you ever suffered from the following (please tick):

- a. Asthma or breathing difficulties
- b. Pain/tightness in the chest
- c. High blood pressure
- d. High cholesterol/triglycerides
- e. Rheumatic fever
- f. Any heart or stroke condition
- g. Gout
- h. Dizziness
- i. Diabetes
- j. Chronic cough
- k. Stomach/duodenal ulcer
- l. Liver/Kidney condition
- m. Arthritis/joint pain
- n. Muscular pain
- o. Lower back pain
- p. Hernia
- q. Cramps
- r. Circulation problems

3. LIFESTYLE:

Do you consider your diet to be: Good / Adequate / Poor

Rate your stress level: High / Moderate / Low

Do you smoke? If yes, how many per day? _________

Are you leading a sedentary lifestyle (do you sit for 6 or more hours a day)? _____________

4. EXERCISE BACKGROUND:

How long has it been since you participated in regular exercise (at least 30 minutes twice a week)? _____________

List other activities you do (eg tennis, running). ____

5. GOALS AND OBJECTIVES:

What do you want to achieve from the classes? ____

I hereby declare that the information furnished is correct to the best of my knowledge. In the event of required medical clearance, I have sought the approval of my medical practitioner to begin an exercise programme.

Signature: ____________________________________ Date: ____

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