DOUGJONES FITNESS

THE GARDEN ISLAND OF KAUAI, HAWAII
THE GOLD COAST OF CONNECTICUT

YOUR PROFESSIONAL SOLUTION TO PRIVATE PERSONAL TRAINING

HEALTH HISTORY QUESTIONNAIRE

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Please complete as completely as possible.
Or, if you prefer, we can discuss answers in person.

PLEASE SEND YOUR COMPLETED FORMS TO DOUG VIA TEXT OR EMAIL AS A SAVED IMAGE OR PDF

WWW.DOUGJONESFITNESS.COM

TEXT PHOTOS OF FORMS TO (808) 652-6453
OR FILES TO DOUG@DOUGJONESFITNESS.COM

Name _____ Age/Birthdate _____ Today's Date _____

Street Address _____ City/State _____

Primary Phone Number _____ Email _____

Physician _____ City/State _____ Date of Last Exam _____

Questions regarding health practices related to risk of certain diseases and history of disease will be asked. Please answer every question so that an accurate assessment can be made. However, **you are free to deny answering any of the following questions**. Your responses will be treated in a confidential manner. For most people, physical activity should not pose any problem or hazard. The following questions have been designed to identify the small number of adults for whom physical activity might be inappropriate or medical guidance is necessary to determine the most suitable types of activities.

What is your blood pressure? _____ What is your total cholesterol? _____

How often do you smoke? _____ Have you smoked in the past? _____

Do you have diabetes? _____ Are you insulin dependent? _____

Have your parents/siblings had coronary/atherosclerotic disease prior to age 55? _____
(high blood pressure, high cholesterol, heart disease, stroke, diabetes, lung disease)

Please list any drugs and dosages (prescription or over-the-counter) that you are taking:

_____

How often do you consume: Caffeine _____ Soda _____ Alcohol _____

Height: _____ Weight: _____ Most you have weighed? _____ At what age? _____

How much did you weigh one year ago? _____ How much did you weigh at age 21? _____

What do you consider to be a good weight for yourself? _____ Goal Date: _____

Have you ever had:	YES	NO
Heart Disease / Rheumatic Fever:	____	____
Artery Disease / Varicose Veins:	____	____
Chest Pain / Discomfort:	____	____
Chest Pressure / Tightness:	____	____
Shortness of Breath:	____	____
Fainting / Lightheadedness	____	____
Arthritis / Gout / Painful Joints:	____	____
Lyme Disease:	____	____
Edema:	____	____
Epilepsy:	____	____
Cancer:	____	____
Back Pain:	____	____
Orthopedic Problems:	____	____

Please describe below any other issues or injuries that you have experienced:

Have you ever exercised regularly? _____ Do you now? _____ Start date? _____

Please describe your current exercise habits including type, frequency, duration, and intensity:

Please briefly describe your daily dietary habits, including how many meals that you typically eat per day, specific types of food, and any special diets that you have used now or ever in the past:

If you desire to lose weight, please describe how you initially developed a problem in controlling your weight (when did it start, how rapidly did weight gain occur, what were your dietary/activity patterns?):

Please provide any additional information that you feel would be helpful. For example: Why did you decide to begin, restart, or modify your fitness routine? What are the specific goals that you wish to achieve through this program? What types of information would you like to learn? Which activities would you like to incorporate into your workouts? What are the specific changes that you would like to make in your fitness level or physique? You can be as general or as specific as you see fit. ☺