

NEWU PARTICIPANT HEALTH HISTORY FORM – Please fill out completely

Participant Name: _____ Age/Date of Birth: _____

Physician’s Name: _____ Physician’s Phone #: _____

Are you taking any medications such as beta blockers, diet pills or herbal supplements that may affect your heart rate or any other aspect of your performance and/or health in this class? If yes, please list:

Name of Medication, Vitamin, Mineral, Amino Acid, Biochemical or Herb	Start Reason

Does your physician know you are participating in this exercise program? _____

Do you have a physician’s release to engage in physical activity? _____

Participant Medical History (circle if applicable)

- | | | |
|----------------------------|-------------------------------------|----------------------------|
| Acne | Fibrocystic Breast Cancer | Multiple Sclerosis |
| Allergic Rhinitis | Fibroid Tumors | Night-Blindness |
| Alzheimer’s Disease | Fibromyalgia | Pancreatitis |
| Arthritis/Rheumatoid/Lupus | Gall Bladder Dysfunction | Parkinson’s Disease |
| Asthma | Gastro Esophageal Reflux | Peptic Ulcer |
| Athletes Foot | Glaucoma | Polycystic Ovarian Disease |
| Cancer | Heart Disease | Postpartum Depression |
| Chronic Fatigue Syndrome | Hepatitis | Psoriasis |
| Chronic Sinusitis | High Cholesterol/High Triglycerides | Ring Worm |
| Colitis | Hypertension | Seizure |
| Collagen | Hyperthyroidism | Stroke |
| Dementia | Hypothyroidism | Thrush |
| Diabetes | Irritable Bowel Syndrome | Toenail/ Fingernail Fungus |
| Eczema | Kidney Problems | Urinary Tract Infections |
| Endometriosis | Liver Disease | Vascular Disease |
| Esophagitis | Menopause | Yeast Infections |

Other: _____

(Continued on back)

General Questions:

Do you now, or have you had in the past: (If yes, please explain in space below)

	YES	NO
1. Recent injury, illness, or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>
2. Chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>
3. Been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
4. Surgery?	<input type="checkbox"/>	<input type="checkbox"/>
5. Frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
6. Head injury?	<input type="checkbox"/>	<input type="checkbox"/>
7. Been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts, or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>
9. Frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>
10. Passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
11. Dizziness during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
12. Seizures?	<input type="checkbox"/>	<input type="checkbox"/>
13. Chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
14. High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
15. History of heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
16. Muscle, joint or back problems/disorders?	<input type="checkbox"/>	<input type="checkbox"/>
17. Diabetes or thyroid condition?	<input type="checkbox"/>	<input type="checkbox"/>
18. Asthma, breathing or lung problems?	<input type="checkbox"/>	<input type="checkbox"/>
19. Difficulty with physical exercise?	<input type="checkbox"/>	<input type="checkbox"/>
20. Advice from a physician NOT to exercise?	<input type="checkbox"/>	<input type="checkbox"/>
21. Pregnancy (now or within the last three months)?	<input type="checkbox"/>	<input type="checkbox"/>
22. Obesity (more than 20% over ideal body weight)?	<input type="checkbox"/>	<input type="checkbox"/>
23. Increased cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
24. History of heart problems in immediate family?	<input type="checkbox"/>	<input type="checkbox"/>
25. Hernia, or any condition aggravated by lifting weights?	<input type="checkbox"/>	<input type="checkbox"/>

Use this space to provide any additional information about the participant's physical health that you think is important or relevant.

If you answered, "yes" to two or more General Question conditions, you may be at increased risk for potential complications during a rigorous exercise program and are advised to seek physician approval before starting a new exercise program. Remember, some form of exercise is almost always recommended, even in cases of increased risk. Exercise is known to help manage and ease conditions such as hypertension and diabetes. But in order to improve your quality of life, you need to make sure you're not aggravating an existing medical condition or performing exercises that for you, may be contraindicated.

I have answered this health history form truthfully and understand it is in my best interest to obtain a physician's release if I am at increased risk:

SIGNATURE: _____ DATE: _____