Health History Form

Name: ________________________________ Program/Activity: ______________________________________

Height: ___________ Weight: _________ Date of Birth: ______________

Do you have medical insurance? Yes No
If yes, who is the provider? ____

Do you have any limiting physical or health disabilities (whether temporary or permanent) that you or your doctor feel would limit your safe participation in the named program/activity? Yes No

Do you have any chronic or recurring injuries? Yes No

Are you pregnant? Yes No Have you had a kidney transplant? Yes No

Current Health Status:

Using the health checklist, please indicate if you have any physical disabilities or conditions that would limit your participation in the program. If you are unsure, please explain the program to your physician and ask for his/her advice. If you check yes to any of these, please give details including any restrictions you may have________________________
____
____

Current Physical Condition:

Please check the highest activity level in each category that you feel you can comfortably attain.

Walking	☐2 miles in 40 minutes	☐4 miles in 80 minutes
	☐6 miles in 120 minutes	☐Unsure
Jogging	☐1 mile in 12 minutes	☐3 miles in 36 minutes
	☐5 miles in 60 minutes	☐Unsure
Cycling	☐ 5 miles in 30 minutes	☐10 miles in 60 minutes
	☐20 miles in 120 minutes	☐Unsure

Swimming Ability:
- ☐ non-swimmer
- ☐ poor
- ☐ fair
- ☐ good
- ☐ very good

Current Exercise Activity:

List any physical activities you engage in, their frequency, duration, and level of intensity.

Activity	Times/Week	Approximate time/distance	Low	Moderate	High

Allergies:

Indicate any allergies (including medications), your reaction, and treatment.

Allergy	Reaction	Treatment

Medications:

What are you currently taking, for what, and will you need it during the named program? If you need it, make sure you have ample supply for the program.

Medication	Condition	Need during program?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Health Checklist:

Please check the following physical disabilities or conditions you have that may limit your participation.

Condition	☐
Hearing or vision problems	☐
Respiratory problems	☐
Back problems	☐
Joint problems	☐
Recent serious illness	☐
Recent surgery	☐
Recent hospitalizations	☐
Serious reaction to high or low temperatures	☐
Frequent muscle cramps	☐
High or low blood sugar	☐
Seizure disorders	☐
Reactions to altitude	☐
Heart problems	☐
Asthma	☐
Other:	

Emergency Contact Information:

Person to notify in case of emergency: ___________________________________ Home phone: _________________

Relationship: ___________ Address: ________________________________ Other phone: __________________