Health History Form

Name:					Prograr					
Height:				Weight:			Date of Birth:			
Do you have medical insurance? If yes, who is the provider?			Yes		No					
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 injuri				g injuries?				Yes	No	
Are you pregnant? Yes No Have you					a kidney	trans	splant?	Yes	No	
Using the participation	ation in the	checklist, e progran	please ind	re unsure, please	explain th	e pro	ogram to	your phys	ions that would limit your sician and ask for his/her adv	
	•			Please check the h	nighest ac	ctivity	y level in	each	Harlet Olaratillar	
		ı teel you s in 40 m		ortably attain.	inutoo				Health Checklist:	_
Valking				☐4 miles in 80 minutes			Swimming Ability: non-swimmer		Please check the following physical disabilities or conditions you have that may limit your	
		s in 120 r		□Unsure						
ogging □1 mile in 12 minutes				□3 miles in 36 minutes			□ poor □ fair		participation.	
	□5 miles in 60 minutes			□Unsure					Condition	
Cycling		es in 30 m es in 120		☐10 miles in 60 minutes ☐Unsure			☐ good☐ very good		Hearing or vision	
	L20 IIIII	C3 III 120	minutes	Поправо		J L	□ very g	Jood	problems	
Current Exercise Activity: List any physical activities you engage in, their									Respiratory problems	
		ities you	eng	age in, th	neir	Back problems				
frequency, dura							The Later Lies		Joint problems	
Activity	I ime	es/VV eek	Approxi	mate time/distance	Low	IVI	oderate	High	Recent serious illness	
									Recent surgery	
									Recent hospitalizations	
									Serious reaction to high	
Allergies: Indicate any allergies (including medications), your reaction, and									or low temperatures	
treatment.							,		Frequent muscle cramps	
Allergy Reaction			Treatment				High or low blood sugar			
									Seizure disorders	
									Reactions to altitude	
									Heart problems	
	ned progra			ntly taking, for wha make sure you have					Asthma Other:	
/ledication)	Conditi	on		Need du	ıring	program	?		•
					☐ Ye		□N			
					☐ Ye		□N			
					☐ Ye	es	□N	lo		
	gency C to notify in			tion: y:				Hor	me phone:	
Relationship: Address: Other phone:										