	Health History Form			
Name:	Date:			
email:	tel#:			
Age:	DOB:	Sex: M F		
	Height:	Weight:		
Physician's Name				
Physician's Phone:				
Person to contact in case of emergency:				
Name:	Phone:			
Are you taking any medications, supplements, or drugs? If so, Please list medication, dose, and reason:				
Does your physician know you are participating in this exercise program?				
Describe any physical activity you do somewhat regularly?				
Do you now, or have you had in the past:			**YES**	**NO**
	1. History of heart problems, chest pain, or stroke			
	2. Elevated blood pressure			
	3. Any Chronic illness or condition			
	4. Difficulty with physical exercise			
	5. Advise from physician not to exercise			
	6. Recent surgery (last 12 months)			
	7. Pregnancy (now or within last 3 months)			
	8. History of breathing or lung problems			
	9. Muscle, joint, or back disorder, or any previous injury			
	affecting you			
	10. Diabetes or thyroid condition			
	11. Cigarette smoking			
	12. Obesity (BMI >/=30)			
	13. Elevated blood cholesterol			
	14. History of heart problems in immediate family			
	15. Hernia, or any condition that may be aggravated			
	by lifting weights or other physical activity			