

Information and Health History Form

Name _____ Date _____

Address (Street, City, State, Zip) _____

Home Phone () _____ Cell Phone () _____

Work Phone () _____ Fax Number () _____

Email _____

Employment (Company, Position) _____

Date of Birth _____ Age _____ Gender: _____ Male _____ Female

Person to Contact in Case of Emergency _____

Phone () _____ Relationship _____

Do you now or have you had in the past:

1. A history of heart problems in immediate family? (mother, father, sibling, grandparent) How old were they?	Yes	No
2. Cigarette smoking or other tobacco habit?	Yes	No
3. Elevated blood pressure or taking blood pressure medication?	Yes	No
4. High cholesterol, triglycerides, or on lipid lowering medications? What is your Total Cholesterol Level?	Yes	No
5. Diabetes or thyroid condition, impaired fasting glucose?	Yes	No
6. Any chronic illness or condition? Please explain:	Yes	No
7. Difficulty with physical exercise?	Yes	No
8. Advice from medical professional not to exercise?	Yes	No
9. Recent surgery? (last 12 months) Please list:	Yes	No
10. Pregnancy (now or within last 3 months)?	Yes	No
11. History of allergy, breathing, or lung problems?	Yes	No
12. Muscle, joint, or back disorder, or any previous injury still affecting you? Please explain:	Yes	No
13. A heart condition or heart or vascular disease?	Yes	No
14. Do you have pain, discomfort, or other anginal equivalent in the chest, neck, jaw, arms, or other areas that may be due to lack of blood flow?	Yes	No
15. Shortness of breath at rest or with mild exertion?	Yes	No
16. Dizziness or fainting?	Yes	No
17. Troubled or rapid breathing at night or the need to sit up to breath?	Yes	No
18. Ankle or leg swelling?	Yes	No
19. Rapid heart beating or palpitations?	Yes	No
20. Calf or leg cramping?	Yes	No
21. A known heart murmur?	Yes	No
22. Unusual fatigue or shortness of breath with usual activities?	Yes	No

Information and Health History Form

What is your current level of activity? (Work and leisure pursuits) _____

Are you currently participating in a regular exercise program? ____ Yes ____ No (please describe)

Are you taking any medication, drugs, vitamins, herbs, or other supplements? If so, please list type, dose, and reason.

Office Location _____

Physician's Name _____ Phone () _____

Office Location _____

Does your physician or specialist know you are participating in this program? ____ Yes ____ No

What are your personal fitness goals? What do you hope to accomplish through personal training?

Adapted, by permission, from Aquatic Exercise Association, 2006, *Aquatic fitness professional manual*, 5th ed. (Champaign, IL: Human Kinetics), 160

From Aquatic Exercise Association, 2007, *AEA Certification Prep* (Champaign, IL: Human Kinetics). • www.AquaticEducationCenter.com • 800-747-4457