



Train your Body

Tailored Plans

Transform your Life

MC SQUARE 135 ROUTE 101A AMHERST, NH 03031 603-204-5993 WWW.TRILOGYFITNESSNH.COM

## HEALTH HISTORY

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

### HEALTH

Do you now or have you in the past:

YES NO

- |  |     |     |
|--|-----|-----|
| 1. History of heart problems, chest pain, or stroke                            | ___ | ___ |
| 2. History of heart problems in your immediate family                          | ___ | ___ |
| 3. Increased blood pressure (higher than 140/90)                               | ___ | ___ |
| 4. Low blood pressure (lower than 100/50)                                      | ___ | ___ |
| 5. Chronic illness or condition  | ___ | ___ |
| 6. Difficulty with physical exercise   | ___ | ___ |
| 7. Advise from a physician not to exercise                                     | ___ | ___ |
| 8. Recent surgery (last 12 months)   | ___ | ___ |
| 9. Diabetes (Type I / Type II)   | ___ | ___ |
| 10. History of breathing or lung problems                                      | ___ | ___ |
| 11. Asthma   | ___ | ___ |
| 12. Muscle, joint, or back disorder or any previous injury still affecting you | ___ | ___ |
| 13. Arthritis  | ___ | ___ |
| 14. Pregnancy (now or within last 3 months)                                    | ___ | ___ |
| 15. Increased blood cholesterol  | ___ | ___ |
| 16. Allergies  | ___ | ___ |
| 17. Light headedness, dizziness, fainting                                      | ___ | ___ |
| 18. Obesity  | ___ | ___ |

### MEDICATIONS

Are you currently taking any medications?

Name of prescription

\_\_\_\_\_

\_\_\_\_\_

What prescription is for

\_\_\_\_\_

\_\_\_\_\_

LIFESTYLE and ACTIVITY

How often do you engage in physical activity outside of your normal work or daily responsibilities? This activity would increase your breathing and heart rate for at least 30 minutes.

- 5 or more times per week     3-4 times per week     1-2 times per week  
 Less than 1 time per week     Seldom or never

Please list the activities that you enjoy

---

---

Are you happy with your current weight? \_\_\_\_\_

Are you presently on a diet or restricted diet? \_\_\_\_\_

What goals do you wish to focus on at Trilogy Fitness?

---

---

What activities do you wish you were better able to enjoy in your everyday life?

---

---