HANNAH WALKER FITNESS

Par Q

Form Name: _____

Date: _____

Telephone: _____

Date of Birth: _____ Age: _____

Height: _____ Weight: _____

In Case of Emergency Contact: _____

Relationship: _____

Address: _____

Phone: _____

Doctors-

Address: _____ Phone: _____

Are you currently under a doctor's care: Yes / No If yes, explain: _____ When was the last time you had a physical examination? _____

Do you take any medications on a regular basis? Yes / No If yes, please list medications and reasons for taking:

_____

Have you been recently hospitalized? Yes/ No If yes, explain:

_____

Do you smoke? Yes / No

Are you pregnant? Yes / No

Do you drink alcohol more than three times/week? Yes / No Is your stress level high? Yes / No

Are you moderately active on most days of the week? Yes / No

Do you have: High blood pressure? Yes / No

High cholesterol? Yes / No

Diabetes? Yes / No

Have parents or siblings who, prior to age 55 had: Yes / No A heart attack? Yes / No

A stroke? Yes / No

High blood pressure? Yes / No
High cholesterol? Yes / No
Known heart disease? Yes /
No Rheumatic heart disease? Yes / No
A heart murmur? Yes / No
Chest pain with exertion? Yes / No
Irregular heart beat or palpitations? Yes / No Lightheadedness or do you faint? Yes / No
Unusual shortness of breath? Yes / No
Cramping pains in legs or feet? Yes / No
Emphysema? Yes / No
Other metabolic disorders (thyroid, kidney, etc.)? Yes / No
Epilepsy? Yes / No
Asthma? Yes / No
Back pain: upper, middle, lower? Yes / No
Other joint pain (explain on back of form)? Yes / No Muscle pain or an injury (explain on back of Form)? Yes / No
To the best of my knowledge, the above information is true.

Signature _____

Date _____

Witness _____

HW
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