Health History

Assess your health needs by marking all TRUE statements:
You have had:

___ heart attack
___ heart surgery
___ cardiac catheterization
___ coronary angioplasty (PTCA)
___ pacemaker/implantable cardiac defibrillator
___ cardiac arrhythmias
___ heart valve disease
___ heart failure
___ heart transplantation
___ congenital heart disease

If you marked any of the statements in this section, you need to consult your healthcare provider before engaging in exercise / VO₂ max testing.

Symptoms:
___ You experience chest discomfort with exertion.
___ You experience unreasonable breathlessness.
___ You experience: dizziness, fainting, blackouts.
___ You take heart medications.

Other Health Issues:
___ You have musculoskeletal problems.
___ You have concerns about the safety of exercise.
___ You take prescription medication(s).
___ You are pregnant.

Cardiovascular Risk Factors:
___ You are a man older than 45 years.
___ You are a woman older than 55 years or you have had a hysterectomy or you are postmenopausal.
___ You smoke.
___ Your blood pressure is >140/90.
___ You take blood pressure medication.
___ Your blood cholesterol level is >240mg/dL.
___ You don’t know your cholesterol level.
___ You have a close blood relative who had a heart attack before age 55 (father or brother) or age 65 (mother or sister).
___ You are diabetic or take medicine to control your blood sugar.
___ You are physically inactive. (ie, you get <30 minutes of physical activity, at least 3 days/week.
___ You are >20 pounds overweight.
___ None of the above is true.  

Please list any allergies (ie: neoprene, latex)
____________________________________________________________
____________________________________________________________

Initials: ______

Signature

Date

Adopted From The ACSM Guidelines 2014
Please briefly describe your current exercise regimen:

Signature

Date

Adopted From The ACSM Guidelines 2014