MUSCLE THEORY

HEALTH HISTORY QUESTIONNAIRE

1.What is your birth date_____

2. Has a doctor diagnosed you with any heart conditions? Yes No
Examples include: mitral valve prolapse, myocardial infarction, angina, dysrhythmia, atherosclerosis of the coronary artery.

3. Has a doctor diagnosed you with any obstructive pulmonary disease? Yes No
Examples include: asthma, interstitial lung disease, emphysema, bronchitis, cystic fibrosis.

4. Has a doctor diagnosed you with any form of metabolic disease? Yes No
Examples include: diabetes mellitus (type 1 or type 2), thyroid disorder, renal or liver disease.

5. Has anyone in your immediate family had any heart problems prior to age 55?
Yes No

6. Have you been diagnosed by a doctor as hypertensive (high blood pressure)?
Yes No

7. Have you been diagnosed by a doctor as having high cholesterol? Yes No

8. Have you been diagnosed by a doctor as having hypoglycemia? Yes No

9. Have you been diagnosed by a doctor as having high triglycerides? Yes No

10. Are you epileptic? Yes No

11. Have you ever suffered a concussion or been knocked unconscious? Yes No

12. Do you smoke (or have you quit within the last 6 months)? Yes No

13. Are you pregnant? Yes No

14. Are you pre or postnatal? Yes No

15. Do you consider yourself to have a sedentary lifestyle (i.e. do you sit a large part of your day)? Yes No

16. Have you ever experienced chest pain? Yes No

17. Have you ever experienced abnormal dizziness? Yes No

18. Have you ever experienced shortness of breath (with mild exertion)? Yes No

19. Are you on any medications right now? Yes No

20. Have you been diagnosed by a doctor as having osteoporosis? Yes No

21. Do you have arthritis or joint pain? Yes No

22. Do you have any back pain or a spine disorder? Yes No

23. Have you ever had any broken bones? Yes No

24. Do you have any musculoskeletal pain/injury? Yes No

25. Are you sensitive to touch or pressure in any area? Yes No

26. Have you ever had a hernia? Yes No

27. Have you ever had surgery? Yes No

28. Do you have difficultly sleeping? Yes No

29. Do you experience poor circulation in your extremities (cold hands and feet)? Yes No

30. Do you have any gastrointestinal disorders? Yes No

32. When was your last complete physical? Yes No

Emergency Contact Information:

_____
Name

_____
Phone Number