



262.439.8601 • peakperformancepros.com

Name _____
Address _____
City _____
State _____ Zip _____
Email _____
Home Phone _____
Work Phone _____
Cell Phone _____
Birthday _____ Age _____

Emergency Contact:
Name _____
Phone _____
Physician _____
Phone _____

HEALTH HISTORY

On this questionnaire a number of questions regarding your physical health are to be answered. Please answer every question as accurately as possible so that a correct assessment can be made. All responses will be held in strictest confidence.

- Yes • No Do you have any personal history of heart disease?
• Yes • No Have you experienced pain or discomfort in your chest that has not been formally diagnosed?
• Yes • No Have you experienced a rapid throbbing or fluttering of the heart?
• Yes • No Do you have a known heart murmur?
• Yes • No Do you have any unaccustomed shortness of breath?
• Yes • No Do you have any difficulty breathing while standing or have sudden breathing problems at night?
• Yes • No Have you had any problem with dizziness or fainting?
• Yes • No Do you suffer form swelling in the ankles?
• Yes • No Have you ever experienced severe leg pain while walking?
• Yes • No Do you have any history of metabolic disease (thyroid, renal, liver)?
• Yes • No Do you have diabetes? If yes, at what age was onset diagnosed?
• Yes • No Have you been told you have high blood pressure on more than two occasions? Last BP ____/____
• Yes • No Has you total cholesterol been measured greater than 240mg/dl?
• Yes • No Has your HDL cholesterol been measured greater than 60 mg/dl?

- Yes • No Are you a cigarette smoker?
• Yes • No Do you have any family history of cardiac or pulmonary disease prior to age 55?
• Yes • No Would you describe your lifestyle as sedentary?

List any surgical procedure you have undergone within the last two years or any other surgery that has resulted in complications that limit your current activities.

Has your Physician ever limited you're activity in any way?

Please list any medications you are currently taking?

Do you have any regular and consistent pain in your

- Feet • Shins • Shoulder • Forearm • Back
• Knees • Calves • Elbow • Upper Arm • Neck
• Hips • Thighs • Wrist • Other

In the space below describe your most recent exercise habits

Table with 4 columns: Activity, Duration, Frequency, Intensity. Includes three rows of blank lines for data entry.

List Your Current Fitness Related Goals

Email completed form to: melissa@peakperformancepros.com, wendy@peakperformancepros.com & bob@peakperformancepros.com