



PGA National Health & Racquet Club

Health History Form

Date: ___/___/___

Name _____ Date of Birth _____

Address _____ Home Phone _____

City _____ State/Zip _____ Work Phone _____

Occupation _____ Emergency Contact _____ Phone _____

Physician's Name _____ Phone _____

DO YOU CURRENTLY HAVE, OR HAVE YOU HAD WITHIN THE PAST YEAR, ANY OF THE FOLLOWING HEALTH RELATED PROBLEMS? IF YES, PLEASE EXPLAIN:

- A CHRONIC ILLNESS
- ASTHMA OR ALLERGIES
- ARTHRITIS
- BRONCHITIS
- BACK PROBLEMS
- CHEST PAIN
- DIABETES
- FAINTING SPELLS
- FAMILY HEART DISEASE
- HIGH BLOOD PRESSURE
- HIGH CHOLESTEROL
- JOINT DYSFUNCTION
- MUSCULAR INJURIES
- NEUROLOGICAL DISORDER
- RAPID HEART BEAT
- SURGERY
- THYROID DISEASE
- OSTEOPOROSIS
- TROUBLE BREATHING
- BROKEN BONES

Please list all drugs (prescription, over the counter meds, herbs or supplements) you are taking.

Drug: _____ Reason: _____

Drug: _____ Reason: _____

Drug: _____ Reason: _____

Have you consulted with you physician about exercising? ___Y___N

Are you actively involved in an exercise program? ___Y___N

Do you smoke cigarettes/cigars? ___Y___N

Do you drink alcohol? ___Y___N If so, how many glasses/bottles a week _____

Please take a few moment to rate yourself in the following categories on a scale of 1 to 5 (1 = poor; 2 = fair; 3 = average; 4 = good; 5 = excellent).

Training knowledge	1	2	3	4	5
Nutritional knowledge	1	2	3	4	5
Resistance to Injury	1	2	3	4	5
Resistance to illness	1	2	3	4	5
Overall Healthy Lifestyle	1	2	3	4	5
Past dedication to training	1	2	3	4	5
Muscle and joint tightness/pain	1	2	3	4	5
Flexibility	1	2	3	4	5
Strength	1	2	3	4	5
Aerobic endurance	1	2	3	4	5
Body Weight (1 = far off from your target weight, no matter if you are over it or under it; 5 = right at your target weight)	1	2	3	4	5
Diet	1	2	3	4	5

What are you fitness goals? _____
