

Health History Questionnaire

Training with Leigh Carter

This form will be kept on file along with your Liability Waiver. A new form will need to be filled out every 8-10 months.

Please fill out this form with great accuracy, as it will help with training and understanding your individual needs.

General Information

Participant

First and Last Name _____ Gender (Circle one) Male Female

Address _____

Phone number(s) _____ Email: _____

Age _____ Birth date _____ *If under 18, must have parent/legal guardian permission (See liability waiver)*

Emergency Contact

First and Last Name _____ Relationship to you _____

Address _____

Phone Number(s) _____

Family Physician and/or Primary Health Care Provider

Doctor _____ Phone _____

Address _____

What is (are) your purpose (s) for participation in Summer Training? What are your goals?

Medical History

Check those questions to which you answer **yes** (*leave the others blank*)

- Has a doctor ever said your blood pressure was too high?
- Do you ever have pain in your chest or heart?
- Are you often bothered by a thumping of the heart?
- Does your heart often race?
- Do you ever notice extra heartbeats or skipped beats?
- Are your ankles often badly swollen?
- Do cold hands or feet trouble you even in hot weather?
- Has a doctor ever said that you have or have had heart trouble, an abnormal electrocardiogram (ECG or EKG), heart attack or coronary?
- Do you suffer from frequent cramps in your legs?
- Do you often have difficulty breathing?
- Do you get out of breath long before anyone else?
- Do you sometimes get out of breath when sitting still or sleeping?
- Has a doctor ever told you your cholesterol level was high?
- Has a doctor ever told you that you have an abdominal aortic aneurysm?**
- Has a doctor ever told you that you have critical aortic stenosis?**

Comments: _____

Do you now have or have you recently experienced

- | | |
|---|--|
| <input type="checkbox"/> Chronic, recurrent or morning cough? | <input type="checkbox"/> Significant vision or hearing problems? |
| <input type="checkbox"/> Episode of coughing up blood? | <input type="checkbox"/> Glaucoma or increased pressure in the eyes? |
| <input type="checkbox"/> Increased anxiety or depression? | <input type="checkbox"/> An infection such as pneumonia accompanied by a fever? |
| <input type="checkbox"/> Problems with recurrent fatigue, trouble sleeping or increased irritability? | <input type="checkbox"/> Significant unexplained weight loss? |
| <input type="checkbox"/> Migraine or recurrent headaches? | <input type="checkbox"/> A fever, which can cause dehydration and rapid heart beat? |
| <input type="checkbox"/> Swollen or painful knees or ankles? | <input type="checkbox"/> A deep vein thrombosis (blood clot)? |
| <input type="checkbox"/> Swollen, stiff or painful joints? | <input type="checkbox"/> A hernia that is causing symptoms? |
| <input type="checkbox"/> Pain in your legs after walking short distances? | <input type="checkbox"/> Foot or ankle sores that won't heal? |
| <input type="checkbox"/> Foot problems? | <input type="checkbox"/> Eye conditions such as bleeding in the retina or detached retina? |
| <input type="checkbox"/> Back problems? | <input type="checkbox"/> Laser treatment or other eye surgery? |
| <input type="checkbox"/> Stomach or intestinal problems, such as recurrent heartburn, ulcers, constipation or diarrhea? | |

Comments: _____

List any *prescription* medications you are now taking: _____

List any *self-prescribed* medications, dietary supplements, or vitamins you are now taking: _____

Date of last complete physical examination: _____ Circle best description of checkup:

Normal Abnormal Never Can't remember

List any other medical or diagnostic test you have had in the past two years: _____

List hospitalizations and/or surgeries including dates of and reasons for hospitalization: _____

Are you cleared by your physician to exercise? Yes No (If no, you will need to get a doctor's note before participating in Summer Training)

List drug allergies: _____

Check those questions to which your answer is **yes** (leave others blank)

- | | |
|---|--|
| <input type="checkbox"/> Heart attack if so, how long ago? | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Diseases of the arteries | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Arthritis of legs or arms | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes or abnormal blood-sugar tests | <input type="checkbox"/> Abnormal chest X-ray |
| <input type="checkbox"/> Dizziness or fainting spells | <input type="checkbox"/> Other lung disease |
| <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Injuries to back, arms, legs or joint |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Nervous or emotional problems | |

Other Heart Disease Risk Factors

Smoking

Have you ever smoked cigarettes, cigars or a pipe? Yes No (*If no, skip to end*)

If you did or now smoke cigarettes, how many per day? _____ Age started _____

If you did or now smoke cigars, how many per day? _____ Age started _____

If you did or now smoke a pipe, how many pipefuls a day? _____ Age started _____

If you have stopped smoking, how long ago was it? _____

Any other additional comments you want/need me to know: _____

Agreement: By signing my name below, I am agreeing that all of the above information is true to the best of my knowledge/ability. I am not lying on this questionnaire and understand that information given is helpful for my health, well-being, and training.

Printed Name

Signature

Date

If under 18, must have parent/guardian signature, as well

Parent/Guardian Name

Parent/Guardian Signature

Date

Training with Leigh Carter Agreement & Release of Liability

1. In consideration of being allowed to participate in the activities and programs of *Leigh Carter* and to use facilities, equipment, and machinery in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge *Leigh Carter* and any officers, agents, employees, representatives, executors, and all other forms and all responsibilities or liability for injuries or damages resulting from my participation in any activities or my use of equipment or machinery in the above-mentioned facilities or arising out of my participation in any activities at said facility. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility of liability for any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others action on their behalf or in any way arising out of or connected with my participation in any activities of *Leigh Carter* or the use of any facilities/equipment or machinery at training sites. I acknowledge and understand that this release is given in advance of any injury or damage to me and that it includes injury or damage to me caused by the ordinary negligence of those released hereby but not from any claims related to gross negligence or willful/wanton/criminal/intentional conduct or acts of those who are otherwise released hereby.

If you understand and agree, please initial _____
If under 18, parent/guardian must initial alongside minor

2. I understand and am aware that strength, flexibility, and aerobic exercise, including the use of equipment, is a potentially hazardous activity. I also understand that fitness activities involve a risk of injury and even death and that I am voluntarily participating in these activities and using equipment and machinery with knowledge of dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death.

If you understand and agree, please initial _____
If under 18, parent/guardian must initial alongside minor

3. I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation in any of the activities and programs of *Leigh Carter* or use of equipment or machinery except as hereinafter stated. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in an exercise/fitness activity or in the use of exercise equipment and machinery. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise, and use of exercise and training equipment so that I might have recommendations concerning these fitness activities and equipment use. I acknowledge that I have either had a physical examination and have been given a physician's permission to participate, or that I have decided to participate in activity and/or use of equipment and machinery without the approval of my physician and do hereby assume all responsibility for my participation and activities, and utilization of equipment and machinery in my activities.

If you understand and agree, please initial _____
If under 18, parent/guardian must initial alongside minor

Printed Name

Signature

Date

If under 18, must have parent/guardian consent

Parent/Guardian Name

Parent/Guardian Signature

Date