

## Renaissance Fitness Health Screen Form

Name: \_\_\_\_\_ Circle: Male Female

Date of Birth: \_\_\_\_\_ Height \_\_\_ ft \_\_\_ in. Weight: \_\_\_\_\_ lbs

Program Name: Personal Training

*This is intended to obtain relevant information about your health that will assist the staff in helping you with your program. Please answer all questions to the best of your knowledge.*

Do you have high blood pressure? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you smoke? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are you a former smoker? \_\_\_\_\_ Yes \* \_\_\_\_\_ No

\* If yes, please give the date you quit \_\_\_\_\_

Do you have diabetes? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you ever had a heart attack? \_\_\_\_\_ Yes \_\_\_\_\_ No

Heart surgery? \_\_\_\_\_ Yes \_\_\_\_\_ No

Angina? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you ever had pain in your chest? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have any of your blood relatives had heart disease, heart surgery or angina?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have any serious orthopedic problems that would prevent you from exercising?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Have you ever had surgery? \_\_\_\_\_ Yes \* \_\_\_\_\_ No

\*If yes, when? \_\_\_\_\_ What type? \_\_\_\_\_

Have you ever had fainting or dizzy spells? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have any reason to believe you should not participate in this program?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Other problems not listed: \_\_\_\_\_

### Emergency Contact

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relation: \_\_\_\_\_ Alt. Number: \_\_\_\_\_