F.A.S.T.
Fitness Athletic Specialized Training

PHYSICAL HEALTH AND MEDICAL QUESTIONAIRE

Note: All information contained in this form is private and strictly confidential. The sole purpose for this information is to aid the trainer in applying appropriate programs. This is not intended to replace a physician's physical. It is recommended that you obtain your physician's approval before beginning any type of fitness/exercise program.

FULL NAME: _____ **DATE:** _____
(LAST) (FIRST) (Middle Intl.)

HOME ADDRESS: _____

BIRTH DATE _____ **AGE** _____ **SEX** _____

WEIGHT _____ **HEIGHT** _____

OCCUPATION: _____

TELEPHONE #(HOME) _____ **BEST TIME TOCONTACT** _____

(WORK) _____ **BEST TIME TO CONTACT** _____

(MOBILE) _____ **BEST TIME TO CONTACT**_____

CONTACT IN CASE OF EMERGENCY: NAME _____

RELATION _____ **PHONE**_____

E-MAIL ADDRESS: _____

MEDICAL HISTORY

A. Date of last full physical examination _____
Did that exam include an exercise stress test? Yes_____ No_____

B. Physician's name and phone number _____ _____

C. Are you currently under the care of a physician? YES _____ NO _____

If yes, Explain _____

D. CARDIOVASCULAR HISTORY

Have you ever had a heart attack, coronary bypass or any form of cardiovascular or cerebrovascular disease? **Y N**

Have you ever experienced any of the following symptoms

- Shortness of breath **Y N**
- Chest Pains **Y N**
  If yes, do they occur upon exertion? **Y N**
- Dizziness/blackouts **Y N**

RISK FACTORS	YES	NO	Please note, If "yes"
High Blood Pressure			**Levels**
Cigarette Smoking (currently)			**How Many / Day**
Have you ever smoked			**For How Long ?** **When Stopped**
Diabetes			
Family History of Heart Disease			**Relation** **Age of Onset**
Abnormal Resting EKG			**Explain**
High Cholesterol			**Levels**

***** If cholesterol is high, were any recommendations given to correct these levels? Yes No
If yes, Please describe _____

E. Orthopedic Injury History (* Designate Left or Right)

	YES	NO	If YES, Explain
Knee *			
Lower Back (Disc or Muscular)			
Neck			
Shoulder *			
Hip / Pelvis *			
Other			

F. Other Medical Considerations

	YES	NO	If YES, Explain
Anemic			
seizures			
Allergies			
Asthma			
Hernias			
Arthritis (osteo or Rheumatoid)			
History of eating disorders			
Pregnancy / Lactation			
Other			

_____ _____

SIGNATURE DATE