Farrell's Extreme Body Shaping
Health History Inventory

Disclaimer: The health history information you provide below is only to be used for evaluation purposes for the FXB program. The information will only be shared on a need to know basis in the event of an emergency.

Participant Name: ____ **D.O.B** ___________________

Personal Health History(check all that apply about past or present conditions):

____	Heart or arterial diseases	___	Stroke
____	Abnormal electrocardiogram (ECG)	___	Anemia
____	High blood pressure	___	Cancer
____	Angina pectoris (chest pain)	___	Asthma
____	Epilepsy	___	Other lung disease
____	Abnormal Chest x-ray	___	Orthopedic or muscular problems
____	Diabetes	___	Eating disorders

If any of the above are checked, please explain further and indicate any recommendations your doctor has made regarding exercise:

____
____
____

Current Medications (Please list name, dosage and reason for each.)

Name	Dosage	Reason
__________________________	________________	____
__________________________	________________	____
__________________________	________________	____
__________________________	________________	____

Family History: (List any condition on the personal health history that a direct relative has.)

Condition	Relationship	Prognosis
___________________	________________	____
___________________	________________	____
___________________	________________	____
___________________	________________	____

Physical Activity Review:

__ Yes ___ No Are you currently involved in a regular aerobic exercise program, such as walking, jogging, cycling, swimming, step aerobics, etc.?

__ Yes ___ No Are you currently participating in weight training?

__ Yes ___ No Do you perform stretching exercises on a regular basis?

What best describes your **level of physical activity** during the past 4 to 6 weeks?

___ Very active ____ Moderately active ___ Occasionally active ___ Inactive

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Smoking:

_____ I currently smoke. ________ Cigarettes/packs per day.(enter amount and circle which.)

_____ I used to smoke. ________________ Quit date (mm/yyyy)

Additional Medical Information: (Anything that may be important for us to know.)

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I hear by attest that the information provided in this document is accurate to the best of my ability. I understand this information will only be used to evaluate my health status for the purpose of participating in the FXB program. Further more, the information may be provided to a health professional in the event of an emergency.

____ ______________________
Participant Signature **Date**

____ ______________________
Witness Signature **Date**