FIT LAB ROCKPORT, LLC

916 HWY 35 South
Rockport, TX 78382
(Physical address)

Personal Health History

Name____ Date______________________

Age_________________ Gender: ☐ Male ☐ Female

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

	Arthritis		Stroke		Back Injury
	Asthma		Visual/Hearing Problems		Muscle/Tendon Injury
	Chest Pain		Heart Attack		Neck Injury
	Heart Disease		High Blood Pressure		Swollen, Stiff or Painful Joints
	Diabetes		Low Blood Pressure		Foot Problems
	Emphysema		Irregular Heartbeats		Knee Problems
	Epilepsy or Seizures		Shoulder Problems		Shortness of Breath
	Fainting or Blackouts		Broken Bones		Recent Surgery
	Head Injury		Hernia		Limited Rang of Motion in Joints

Are you currently under a doctor's care for any of the above conditions? ☐ Yes ☐ No

If yes, please explain:____

List any medication you are taking:

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List any dietary supplements you are taking:

____

____

List any hospitalizations or surgical procedures during this past year:

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Are you pregnant? ☐Yes ☐No ☐N/A If yes, how many weeks? _______________