BODY BY JEAN-FRANÇOIS

HEALTH SCREENING FORM

NAME _____ DATE _____

Home phone # _____ Cell # _____

Work phone # _____

Address _____

Physician's name _____

Physician's Phone # _____

Person to Contact in Case of Emergency

	Relationship	Phone #
Name _____	_____	_____

Are you taking any medication? Yes No What?_____

Does your physician know you are participating in this exercise program?

Describe your exercise program now._____

_____

Do you now or have you had in the past:	Yes	No
1. History of heart problems, chest pain or stroke.	____	____
2. Increased blood pressure.	____	____
3. Any chronic illness or condition.	____	____
4. Difficulty with physical exercise.	____	____
5. Advice from physician not to exercise.	____	____
6. Recent surgery (last 12 months).	____	____
7. Pregnancy (now or within last 3 months).	____	____
8. History of breathing or lungs problems.	____	____
9. Muscle, joint, back disorder, or a past injury still affecting you.	____	____
10. Diabetes or thyroid condition.	____	____
11. Cigarette smoking habit.	____	____
12. Obesity: Body Mass index (BMI) over 30 or higher.	____	____
13. Increased blood cholesterol.	____	____
14. History of heart problems in immediate family.	____	____
15. Hernia, or any condition that may be aggravated by lifting weights.	____	____
16. Please explain any yes answers on the back of this form.		

Comments:_____
_____
_____
_____