GRAND VALLEY STATE UNIVERSITY

RECREATION

PERSONAL TRAINING MEDICAL HISTORY

Name:_____ Date of Birth:_____

Phone #: _____Affiliation:(circle) **Student Faculty/Staff Other**

Home Address:_____

G #: _____ Email adress: _____

Physician's Name:_____Physician's Phone #: _____

Physician's Address: _____

Emergency Contact:_____ Relation: _____ Phone #:_____

1. Do you experience any of the following symptoms

	NO	YES	IF YES, WHEN/DESCRIPT
Chest discomfort with exertion	☐	☐	_____
Unreasonable breathlessness	☐	☐	_____
Dizziness, fainting, blackouts	☐	☐	_____
Ankle swelling	☐	☐	_____
Unpleasant awareness of a forceful, rapid, or irregular heart rate	☐	☐	_____
Burning or cramping sensations in your lower legs when walking short distance	☐	☐	_____

Comments: _____

2. Have you performed planned, structured physical activity for at least 30 minutes at moderate intensity on at least 3 days per week for at least the last 3 months? No ☐ Yes ☐

3. Have you had in the past or currently have any of the following medical conditions?

	NO	YES	IF YES, WHEN/DESCRIPT
Heart attack	☐	☐	_____
Heart surgery, cardiac catheterization, or coronary angioplasty	☐	☐	_____
Pacemaker/implantable cardiac defibrillator/rhythm disturbance	☐	☐	_____
Heart valve disease	☐	☐	_____
Heart failure	☐	☐	_____
Heart transplantation	☐	☐	_____
Congenital heart disease	☐	☐	_____
Diabetes	☐	☐	_____
Renal disease	☐	☐	_____

Comments: _____

4. Do you have asthma or any other pulmonary problems? ☐ NO ☐ YES

Comments _____

5. Have you had any surgery as a result of an injury? ☐ NO ☐ YES

Body region and when: _____ Rehabilitation/therapy: ☐ NO ☐ YES

Comments: _____

6. Do you have a neuromuscular disorder, rheumatoid disorder or muscular problem that is worsenedby physical activity? ☐ NO ☐ YES

If so, explain the problem, **body region affected** and **when** the pain occurs? _____

_____

7. Do you have any medical, physical or emotional conditions (including pregnancy) which would require a modified exercise program? ☐ NO ☐ YES Comments:

_____

8. List any medications you are currently taking:

	Medication	Prescribed For	Taken Since
1.			
2.			
3.			

Comments: _____

9. Smoking status: ☐ Never Smoked ☐ Used to Smoke ☐ Socially ☐ Currently Smoke*

*Packs per day (amount):_____ *Number of years smoked:_____

If you quit smoking, what year did you quit? _____

10. How many days per week do you currently exercise: ☐ 6-7 ☐ 3-5 ☐ 2-1 ☐ None

How long do you typically exercise: ☐ 60+min ☐ 30+ min ☐ 20-29 min ☐ 10-19 min ☐ < 10 min

At what level or intensity do you typically exercise: ☐ Vigorous ☐ Moderate ☐ Low

11. What is the date of your last physical/check up? _____

The above stated information is true and accurate to the best of your knowledge.

Signature:_____ **Date:** _____

Office Use Only

Symptoms: NO (continue) YES (HCP)

Current activity/Medical Conditions: NO/YES (HCP) NO/NO (light-mod) YES/YES (light-mod)

HCP: YES / NO Intensity:_____ Initials:_____ Date: _____

Supervisor signiture:_____ Date:_____

GRAND VALLEY STATE UNIVERSITY
RECREATION

PERSONAL TRAINING RECORD REQUEST

Date: _____

In order to comply with all patient confidentiality guidelines, we are requesting that you complete this release form, which will allow us to communicate with your physician, therapist, coach or other provider, if we have any concerns related to your medical history. If you do not currently have a physician, please list your most recent physician's information and date of last visit.

We are requesting that health care provider consent be issued to:

GVSU Fitness & Wellness Services
Attention: Amy Campbell
D135 Recreation Center
Allendale, Michigan 49401-9403

Provider consent is being requested from (Doctor, therapist, coach or other provider):

Provider's Name: _____

Provider's Address: _____

_____

I _____, am aware that the Grand Valley State University Fitness & Wellness Center is communicating with my health care provider and hereby give permission to do so.

Client Information:

Name: _____
(Please Print)

Signature: _____

Date of Birth: _____Phone Number: _____

Address: _____

_____

Reason for requesting records: _____

_____