



Name _____

Address _____

Phone (H) _____

(C) _____

Medical History Questionnaire

CrossFit All In

This is your medical history form, to be completed prior to your first training session with CrossFit All In. All information will be kept confidential. This information will be used for the evaluation of your health and readiness to begin our exercise program. Your answers will help us design a comprehensive program that meets your individual needs. You will want to make sure it is as accurate and complete as possible. Please fill out the form carefully and thoroughly, then review it to be certain you have not left anything out.

Current Blood Pressure ___ / ___

Current Heart Rate ___BPM



Medical History and Screening Form

Client:

Name _____

Address _____

Phone _____

Birthdate _____

Marital Status:

Single Married Divorced Widowed

Sex:

Male Female

Occupation:

Position _____

Employer _____

Briefly explain your health and fitness goals and what you hope to gain by starting Crossfit:



Present Medical History

Check those questions to which your answer is yes (leave the others blank).

- Has a doctor ever said your blood pressure was too high?
- Do you ever have pain in your chest or heart?
- Are you often bothered by a thumping of the heart?
- Does your heart often race like mad?
- Do you ever notice extra heartbeats or skipped beats?
- Are your ankles often badly swollen?
- Do cold hands or feet often trouble you even in hot weather?
- Has a doctor ever said that you have or had heart trouble, an abnormal electrocardiogram (ECG or EKG), heart attack, or coronary?
- Do you suffer from frequent cramps in your legs?
- Do you often have difficulty breathing?
- Do you get out of breath long before anyone else?
- Do you sometimes get out of breath when sitting still or sleeping?
- Has a doctor ever told you your cholesterol level was high?

Do you now have or have you recently experienced:

- Chronic, recurrent, or morning cough?
- Episode of coughing up blood?
- Increased anxiety or depression?
- Problems with recurrent fatigue, trouble sleeping, or increased irritability?
- Migraine or recurrent headaches?
- Swollen or painful knees or ankles?
- Swollen, stiff, or painful joints?
- Pain in your legs after walking short distances?
- Foot problems?
- Back problems?
- Stomach or intestinal problems, such as recurrent heartburn, ulcers, constipation, or diarrhea?
- Significant vision or hearing problems?
- Recent change in a wart or a mole?
- Glaucoma or increased pressure in the eyes?
- Exposure to loud noises for long periods of time?

Comments:



Women only answer the following. Do you have:

- Menstrual period problems?
- Significant childbirth-related problems?
- Urine loss when you cough, sneeze, or laugh?

Comments:

Are you on any type of hormone replacement therapy?

Men and women answer the following:

List any prescription medications you are now taking:

List self-prescribed medications or dietary supplements you are now taking:

Date of last complete physical examination: _____

Normal Abnormal Never Can't remember

Date of last chest x-ray: _____

Normal Abnormal Never Can't remember

Date of last Electrocardiogram (ECG or EKG): _____

Normal Abnormal Never Can't remember

List any other medical or diagnostic test you have had in the past two years:

List hospitalizations, including dates of and reasons for hospitalization:

List any drug allergies:



Past Medical History

Check those questions to which your answer is yes (leave the others blank).

- Heart attack If so, how many years ago? _____
- Rheumatic fever
- Heart murmur
- Diseases of the arteries
- Varicose veins
- Arthritis of legs or arms
- Diabetes or abnormal blood-sugar tests
- Phlebitis (inflammation of a vein)
- Dizziness or fainting spells
- Epilepsy or seizures
- Stroke
- Diphtheria
- Scarlet fever
- Infectious mononucleosis
- Nervous or emotional problems
- Anemia
- Thyroid problems
- Pneumonia
- Bronchitis
- Asthma
- Abnormal chest x-ray
- Other lung disease
- Injuries to back, arms, legs, or joints
- Broken bones
- Jaundice or gall bladder problems

Comments:



Family Medical History

Father:

Alive Current age: _____

My father's health is:

Excellent Good Fair Poor

Reason for poor health:

Deceased Age at death: _____

Cause of death:

Mother:

Alive Current age: _____

My mother's health is:

Excellent Good Fair Poor

Reason for poor health:

Deceased Age at death: _____

Cause of death:

Familial Diseases

Have you or your blood relatives had any of the following? (Include grandparents, aunts and uncles, but exclude cousins, relatives by marriage, and half-relatives.)

Check those to which the answer is yes (leave others blank).

Heart attacks under age 50

Strokes under age 50

High blood pressure

Elevated cholesterol

Diabetes

Asthma or hay fever

Congenital heart disease (existing at birth but not hereditary)

Heart operations

Glaucoma

Obesity (20 or more pounds overweight)

Leukemia or cancer under age 60

Comments:



Other Risk Factors

Smoking

Have you ever smoked cigarettes, cigars, or a pipe?

Y N

(If no, skip to Diet section)

If you did or now smoke cigarettes, how many per day? _____

Age started _____

If you did or now smoke cigars, how many per day? _____

Age started _____

If you did or now smoke a pipe, how many pipefuls a day? _____

Age started _____

If you have stopped smoking, when was it?

If you now smoke, how long ago did you start?

Diet

What do you consider a good weight for yourself? _____

Current weight: _____

Number of meals you usually eat per day: _____

Do you eat breakfast? Yes / No

What time of day is your first meal? _____

Amount of water you drink per day: _____

How would you rate your sugar intake (consider soda, candy, juice, yogurt, coffee drinks and Gatorade when answering)? High / Moderate / Low

How would you rate your refined carbohydrate intake (consider bread products, white rice, pastries and noodles when answering)? High / Moderate / Low

How would you classify your current diet (circle one)?

Low Fat / Low Carb. / Balanced / High Fat / High Carb / High Calorie / Don't Know



Do you ever drink alcoholic beverages?

Y N

If yes, what is your approximate intake of these beverages?

Beer:

None Occasional Often If often, _____ per week

Wine:

None Occasional Often If often, _____ per week

Hard Liquor:

None Occasional Often If often, _____ per week

At any time in the past, were you a heavy drinker (consumption of six ounces of hard liquor per day or more)?

Y N

Comments:

Signature of client

Date