MILLERSVILLE UNIVERSITY - PUCILLO FITNESS ROOM

First Name: _____ **Last Name:** _____
Date of Birth: _____ **Sex:** _____
Phone: (H) _____ (W) _____
E-mail: _____

Person to be contacted in case of an emergency: _____
Phone: (H) _____ (W) _____
Physician's Name: _____ **Phone:** _____
Address: _____

Questions:

1. Have you had a physical from your physician within the past year?	Y / N
2. Has a physician ever advised you not to exercise?	Y / N
3. Have you ever been given an exercise prescription by a physician?	Y / N
4. Have you ever or do you have difficulty with physical exercise?	Y / N
5. Is there a history of hearing problems within your immediate family?	Y / N
6. Do you have high blood pressure?	Y / N
7. Do you have Diabetes? If so, do you take insulin?	Y / N Y / N
8. Have you ever had a history of respiratory or lung problems?	Y / N
9. Are you currently on any medications that directly affect the heart, lungs, or circulatory system (i.e. Blood Pressure Medications)? If yes, Please list: _____ _____	Y / N
10. Do have high blood cholesterol?	Y / N / Don't Know
11. Do you have thyroid problem?	Y / N
12. Do you have a chronic illness or condition?	Y / N
13. Do you have a hernia, or any condition that may be aggravated by lifting weights?	Y / N
14. Do you have an infectious or communicable disease?	Y / N
15. Have you had surgery within the past 12 months?	Y / N
16. Do you have any muscle, joint, back injury, or any previous injury still affecting you?	Y / N
17. Are you currently pregnant or have been within the past 3 months?	Y / N

If you have answered YES to any of the above questions, please explain below. Also please list any information that you feel we should know before setting you up on an exercise program:

_____

_____

Your Signature: _____