



MEDICAL AND PHYSICAL ACTIVITY HISTORY

Date: _____ **Date of Birth:** _____
Name: _____ **Age:** _____
Address: _____ **Zip Code:** _____

In case of an emergency, whom may we contact?

Name: _____ **Relationship:** _____
Phone (H): _____ **(W):** _____ **(C):** _____

Past Medical History: (please check all that apply)

Rheumatic Fever	<input type="checkbox"/>	Recent Operations	<input type="checkbox"/>	Chronic Swelling	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Back Injuries	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>
Knee Injuries	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Other	<input type="checkbox"/>

Explain all checked items:

Family Medical History: (please check all that apply)

Heart Attacks	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Congenital Heart Disease	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	Other Major Illness	<input type="checkbox"/>

Explain All Checked Items:

Activity History:

1. How did you learn about Great Plains Maximum Performance? _____

2. Why are you considering enrolling in the programs available at Maximum Performance? _____

3. List in order your personal fitness/performance goals: _____



4. Are you presently employed? YES _____ NO _____
5. What is your present occupation? _____
6. Name of company? _____
7. Are you currently a student? YES _____ NO _____ Full-time ___ Part-time _____
8. What school do you attend? _____
9. What sports do you play? _____
10. What year of education are you currently in? _____
11. What type of degree are you pursuing? _____
12. Are you participating in a regular exercise program at this time?
YES _____ NO _____
If yes, briefly describe _____
13. Do you have any injuries that interfere with exercising? YES _____ NO _____
If yes, please describe _____
- _____
- _____
14. Do you smoke? YES _____ NO _____
If yes, how much per day and age when you started? _____ per day _____ age
15. Are you currently involved in a weight management program?
YES _____ NO _____
16. Please list any medications and you are currently taking and reasons for taking them: _____
- _____
17. Are you pregnant? YES _____ NO _____
If yes, do you have a history of any pregnancy complications?
YES _____ NO _____ Please describe _____
- _____
18. Have you ever been diagnosed with sleep apnea? YES _____ NO _____
If yes, do you use a CPAP machine? YES _____ NO _____
Have you ever had a sleep study performed? YES _____ NO _____
If yes to any of the above questions, please explain:

