



PEAK PERFORMANCE, LLC

Northern Colorado's Premier Athletic Training Program

Health History Questionnaire

Name _____
Address _____
Phone (home) _____ (work) _____ (cell) _____
Age _____ Birth Date _____ Occupation _____
Physician's name _____ Physicians Phone _____
Physician's address _____

Family History

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Have you ever had, or has your doctor ever diagnosed you as having heart trouble or coronary disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Do you have a family history of heart problems or coronary disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Do you have a history of high blood pressure? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Have you recently surgery or experienced bone, muscle, tendon, or ligament problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you have diabetes? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Do you smoke cigarettes? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Are you overweight? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Is your diet heavy in fatty foods and red meat? |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you ever have pains in your heart or chest? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you ever feel faint or have dizzy spells? |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Has your doctor ever said you have high cholesterol? |
| | | 12. Resting EKG _____ |
| | | 13. Total Cholesterol/HDL ratio: _____ |

Medical History

1. Check any condition or disease you **now** have or **have had** in the past.

- | | |
|--|--|
| <input type="checkbox"/> Heart Attack, or cardiac surgery | <input type="checkbox"/> Cold hands or feet |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Unusual shortness of breath |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Light-headedness or fainting |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Epilepsy or seizures |
| <input type="checkbox"/> Phlebitis or emboli | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Low Blood pressure | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Chest Discomfort | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Chronic cough |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Increased anxiety or depression |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Emotional Disorders |
| <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Fatigue or lack of energy |
| <input type="checkbox"/> Migraine or recurrent headaches | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Swollen, stiff, or painful joints | <input type="checkbox"/> Stomach or intestinal problems |
| <input type="checkbox"/> Foot problems | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Limited range of motion in joints |
| <input type="checkbox"/> Shoulder problems | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Neck problems | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Broken bones | |

If you checked any of these please explain here:

2. Please list any prescribed medications you are now taking

3. Please list any over-the-counter medications or dietary supplements you are now taking.

4. Please list any illness, hospitalization, or surgical procedures within the past 3 years.
(or if they pose restrictions on exercise training)

5. Please list any drug allergies.

6. Please list date of last physical examination and the results.

7. Are there any other comments you would like to make concerning your health?

I do hereby state that I have, to the best of my knowledge and belief, given a correct and accurate medical history report.

Signature

Date

Parent or Guardian Signature (if under age of 18)

Date

Peak Performance Representative

Date

“YOU ARE PURE POTENTIAL”