UpLift Member Health History Form

Member Name: _____

Date of Birth: _____ Age: _____

1st Contact in the event of emergency: _____

Phone # _____

2nd Contact in the event of emergency: _____

Phone # _____

Physician's name: _____

Physician's phone number: _____

Are you taking any medication? If so, please list medication(s), dosage and reason:

_____

_____

_____

Does your physician know you are participating in an exercise program? _____

Do you now, or have you had:	Yes	No
1. History of heart problems, chest pain or stroke	_____	_____
2. Increased blood pressure	_____	_____
3. Any chronic illness or condition	_____	_____
4. Difficulty with physical exercise	_____	_____
5. Advice from physician not to exercise	_____	_____
6. Pregnancy (now or within last three months)	_____	_____
7. Recent surgery (last 12 months)	_____	_____
8. History of breathing or lung problems	_____	_____
9. Muscle, joint or back disorder, or any injury still affecting you	_____	_____
10. Diabetes or thyroid condition	_____	_____
11. Cigarette smoking habit	_____	_____
12. Obesity (more than 20 percent over ideal body weight)	_____	_____
13. Increased blood cholesterol	_____	_____
14. History of heart problems in immediate family	_____	_____
15. Hernia, or any condition that may be aggravated by lifting weights	_____	_____

Please explain any "yes" answers:

_____

_____

_____

_____

Signature: _____ Date: _____