



HEALTH & MEDICAL HISTORY

	Yes	No
1. Does your physician approve of your participation in this exercise program?		
2. Are you taking any medications that affect your vital signs (heart rate, blood pressure, breathing, etc.) or physical performance?		
3. Are you a post-menopausal female?		
4. Rate your current fitness level (1=lowest 10=highest)		

5. List Height and Weight

<i>Do you now, or have you had in the past:</i>	Yes	No
6. History of heart problems in the immediate family		
7. Cigarette, cigar, or pipe smoking habit		
8. Increased blood pressure		
9. Increased total blood cholesterol (>200 mg/dL)		
10. Diabetes mellitus		
11. History of heart problems, chest pain, or stroke		
12. History of breathing or lung problems		
13. Muscle, joint, back disorder, or any previous injury still affecting you		
14. Hernia or any condition that may be aggravated by lifting weights?		
15. Any chronic illness or condition		
16. Obesity (more than 20% over ideal body weight)		
17. Recent surgery (last 12 months)		
18. Pregnancy (now or within last year)		
19. Difficulty with physical exercise		
20. Advice from physician not to exercise		

Please explain any answers below:



Name:	Email:	Phone:	T-Shirt Size:
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Address:	How did you Hear About Us:	Desired Camp /Start Time:
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Preferred Payment:	Are you Joining with a Friend:
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