HIAWATHA'S MARTIAL ARTS

Health Checklist

STUDENT NAME: _____

DATE: _____ SEX: _____ AGE:_____

PHYSICIAN'S NAME: _____

PHYSICIAN'S PHONE: _____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____

RELATIONSHIP: _____ PHONE: _____

ARE YOU TAKING ANY MEDICATIONS OR DRUGS?: Y/N: ___ TYPE: (S):_____

Does your physician know you are participating in this exercise program:	Y/N: _____
Have you participated in an exercise program	Y/N: _____
History or heart problems, chest pain, or stroke:	Y/N: _____
Increased blood pressure: History or heart problems, chest pain, or stroke:	Y/N: _____
Any chronic illness or condition:	Y/N: _____
Difficulty with physical Exercise:	Y/N: _____
Advice from physician to not exercise	Y/N: _____
Recent surgery (last 12 months)	Y/N: _____
Pregnancy (now or within last 3 months)	Y/N: _____
History of breathing or lung problems	Y/N: _____
Muscle, joint, back disorder, or prior injury still effecting you	Y/N: _____
Diabetes or thyroid condition	Y/N: _____
Smoker	Y/N: _____
Obesity (more then 20% over ideal body weight)	Y/N: _____
Increased cholesterol	Y/N: _____
Family history of heart problems	Y/N: _____
Hernia or any other condition that may be aggravated by lifting weights	Y/N: _____

Comments: _____