**Health History Questionnaire**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (H)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age:\_\_\_\_\_\_\_\_\_\_ Birthday:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

**Yes No**

\_\_\_ \_\_\_ Has your doctor ever said you have a heart condition and that you should

only do physical activity recommended by a doctor?

\_\_\_ \_\_\_ Do you feel pain in your chest when you do physical activity?

\_\_\_ \_\_\_ Have you ever experienced a racing heart rate, skipped beats, or extra

heartbeats at rest?

\_\_\_ \_\_\_ Have you ever had an EKG taken while exercising (or a stress test)?

\_\_\_ \_\_\_ Do you lose your balance because of dizziness or do you ever lose consciousness?

\_\_\_ \_\_\_ Do you, or have you ever had, high blood pressure?

\_\_\_ \_\_\_ Is your doctor currently prescribing drugs (for example, water pills) for your blood

pressure, heart condition, or diabetes?

\_\_\_ \_\_\_ Do you know of any other reason why you should not participate in

physical activity?

If you marked “Yes” to one or more of the above, you must obtain your personal physician’s consent prior to scheduling your fitness assessment.

|  |  |  |  |
| --- | --- | --- | --- |
| Height:\_\_\_\_\_\_\_\_\_\_  Weight:\_\_\_\_\_\_\_\_\_\_ | Usual blood pressure:  \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ | Cholesterol level: \_\_\_\_\_\_\_\_\_\_\_ |  |

Date of last Physical\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Anemia (severe)

\_\_\_ Arthritis Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Asthma

\_\_\_ Chronic back problems

\_\_\_ Chronic fatigue

\_\_\_ Diabetes

\_\_\_ Hernia, or any condition that may be aggravated by lifting weights

\_\_\_ High blood cholesterol

\_\_\_ Hypoglycemic

\_\_\_ Orthopedic problems (joint or bone problems) Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Pregnant (or within the past 3 months)

\_\_\_ Smoker? \_\_\_\_\_ Packs/day? \_\_\_\_\_ Have you ever smoked? \_\_\_\_\_ How long ago?

Are you allergic or intolerant of any foods? \_\_\_Yes \_\_\_No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have digestive considerations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have menstrual considerations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have menopausal considerations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a family history of heart, lung or respiratory disease (parents or siblings before age 55)?

List relationship and age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Major surgery or hospitalization (within the past 6 months)

Please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all drugs (prescription and over-the-counter medications) you are currently taking:

Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list below any other concerns you may have regarding either your fitness level or the exercise program you are going to take part in.

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