Health History Questionnaire

NAME: _____ Date: _____ DATE OF BIRTH: _____

Have you previously been tested for an exercise program? ___Y ___N Last test: _____

HOME PHONE #:_____ CELL PHONE #:_____

PRIMARY PHYSICIAN: _____

PHYSICIAN PHONE #: _____ FAX #: _____

SPECIALIST (*PT, Cardiologist, etc.*): _____

SPECIALIST PHONE #: _____ FAX #: _____

In case of emergency, contact: _____ PHONE#: _____

PLEASE CHECK YES or NO

PAST HISTORY		
(Have you ever had?)	YES	NO
High blood pressure.....	☐	☐
Any heart trouble.....	☐	☐
Disease of the arteries.....	☐	☐
Lung disease.....	☐	☐
Asthma.....	☐	☐
Hepatitis.....	☐	☐
Diabetes.....	☐	☐
Heart murmur.....	☐	☐
Arthritis.....	☐	☐

FAMILY HISTORY		
(Have any of your immediate family or grandparents had?)	YES	NO
Heart attacks.....	☐	☐
High blood pressure.....	☐	☐
High cholesterol.....	☐	☐
Stroke.....	☐	☐
Diabetes.....	☐	☐
Congenital heart defect.....	☐	☐
Heart operations.....	☐	☐
Other family illness.....		
.....		

PRESENT SYMPTOMS		
(Have you recently had?)	YES	NO
Chest pain/discomfort.....	☐	☐
Shortness of breath.....	☐	☐
Heart palpitations.....	☐	☐
Irregular heart beats.....	☐	☐
Frequent headaches.....	☐	☐
Dizzy spells.....	☐	☐
Frequent colds.....	☐	☐
Back pain.....	☐	☐
Orthopedic problems.....	☐	☐

Please list any recent hospitalizations/surgeries:

_____

_____

Any other medical problems/concerns not already identified? YES ____ NO ____ (Please list below)

_____

_____

(FOR STAFF)

_____

_____

_____

_____

Have you ever had your cholesterol measured? YES ____ NO ____ (value) _____ (Date) _____

Are you taking any Prescription or Non-Prescription medications? YES ____ NO ____ (including birth control)

Medication	Reason for taking medication	For how long?

Do you currently smoke? YES ____ NO ____

How much per day: < .5 pack ___ 0.5 to 1 pack ___ 1.5-2 packs ___ > 2 packs ___

Have you ever quit smoking? YES ____ NO ____ **When?** _____ **How many years did you smoke?** ____

Do you drink any alcoholic beverages? YES ____ NO ____ If yes, how much in 1 week?

Beer _____(cans) Wine _____(glasses) Hard liquor _____(drinks)

ACTIVITY LEVEL EVALUATION

Do you currently engage in vigorous physical activity on a regular basis? YES ____ NO ____

If so, what type? _____

How many times per week? _____ How much time per day? _____

Do you ever have an uncomfortable shortness of breath during exercise? YES ____ NO ____

Do you ever have chest discomfort during exercise? YES ____ NO ____ If so, does it go away with rest? _____

Are you currently following a weight reduction diet plan? YES ____ NO ____

If so, how long have you been dieting? _____months Is the plan prescribed by your doctor? YES or NO

Have you used weight reduction diets in the past? YES ____ NO ____

If yes, how often and what type?

_____

Please indicate the reason you want to start an exercise program.

To lose weight _____ Doctor's recommendation _____ For good health _____ Enjoyment _____

Release of tension _____ Improve physical appearance _____ Other _____

I have filled out this form to the best of my knowledge:

Signature: _____ **Date:** _____