HEALTH HISTORY QUESTIONNAIRE

NAME_____AGE_____DATE_____DATE OF BIRTH_____
First M.I. Last day/month/yr day/month/yr

ADDRESS_____
Street City/State/Zip

TELEPHONE (home)_____(business)_____(cell)_____

OCCUPATION_____PLACE OF EMPLOYMENT_____

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED

SPOUSE:_____

EDUCATION: (check highest level) ELEMENTARY_____ HIGH SCHOOL_____ COLLEGE_____

GRADUATE_____

ETHNICITY:_____ PERSONAL PHYSICIAN_____

LOCATION_____

Reason for last doctor visit?_____ Date of last physician exam_____

Have you previously been tested for an exercise Program? YES _____ NO _____ YEAR(s) _____

LOCATION OF TEST_____

Person to contact in case of an emergency_____ Phone #_____

(relationship)_____

PLEASE CHECK YES or NO

PAST
(Have you ever had?)

	YES	NO
High blood pressure	☐	☐
Heart problems	☐	☐
Disease of the arteries	☐	☐
Varicose veins	☐	☐
Lung disease	☐	☐
Asthma	☐	☐
Kidney disease	☐	☐
Hepatitis	☐	☐
Diabetes	☐	☐
Orthopedic problems	☐	☐
Arthritis	☐	☐

FAMILY
(Have any immediate family or grandparents had?)

	YES	NO
Heart attacks	☐	☐
High blood pressure	☐	☐
High cholesterol	☐	☐
Stroke	☐	☐
Diabetes	☐	☐
Congenital heart defect	☐	☐
Heart operations	☐	☐
Early death	☐	☐

Other family illness _____

_____

_____

PRESENT SYMPTOMS
(Have you recently had?)

	YES	NO
Chest pain/discomfort	☐	☐
Shortness of breath	☐	☐
Dizzy spells	☐	☐
Skipped heart beats	☐	☐
Trouble sleeping	☐	☐
Ankle swelling	☐	☐
Leg pain/cramping	☐	☐
Frequent headaches	☐	☐
Frequent colds	☐	☐
Back pain	☐	☐
Orthopedic problems	☐	☐

(FOR STAFF COMMENTS)

_____

_____

_____

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HOSPITALIZATIONS: Please list recent hospitalizations (Women: do not list normal pregnancies)

Year Location Reason

Any other medical problems/concerns not already identified? Yes_____ No_____ (Please list below)

Have you ever had your cholesterol measures? Yes_____ No_____; If yes, (value)_____ (Date)_____

Are you taking any Prescription or Non-Prescription medications? Yes_____ No_____ (include birth control pills)

Medication Reason for Taking For How Long?

Do you currently smoke? Yes_____ No_____ If so, what? Cigarettes_____ Cigars_____ Pipe_____

How much per day: < .5 pack_____ 0.5 to 1pack_____ 1.5 to 2 packs_____ > 2 packs_____

Have you ever quit smoking? Yes_____ No_____ When?_____ How many years and how much 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)

Do you drink any caffeinated beverages? Yes_____ No_____ If Yes, how much in 1 week?

Coffee_____(cups) Tea_____(glasses) Soft drinks_____(cans)

ACTIVITY LEVEL EVALUATION

What is your occupational activity level? sedentary_____; light_____; moderate_____; heavy_____

Do you currently engage in vigorous physical activity on a regular basis? Yes_____ No_____

If so, what type?_____ How many days per week?_____

How much time per day? (check one) < 15 min_____ 15–30 min_____ 30–45 min_____ > 60 min_____

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?_____

Do you engage in any recreational or leisure-time physical activities on a regular basis? Yes_____ No_____

If so, what activities?_____

On average: How often?_____times/week; For how long?_____time/session

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Are you currently following a weight reduction diet plan? Yes_____ No_____ Name:_____

If so, how long have you been dieting? _____months Is the plan prescribed by your doctor? Yes_____ No_____

Have you used weight reduction diets in the past? Yes_____ No_____; If yes, how often and which type(s)?

_____

Please indicate the reasons why you want to join the exercise program.

To lose weight _____ Doctor's recommendation_____ For good health _____ Enjoyment_____

Release of tension_____ Improve physical appearance _____ Other _____

FOR STAFF USE:

_____

_____