

Health History Questionnaire

Last name _____ First name _____

Phone _____ E-mail address _____

Home address _____

In case of emergency contact _____ Emergency Contact Phone _____

Personal physician _____ Physician's Phone _____

Your Date of birth _____ Your Age _____

This required Health History Questionnaire provides information on your current level of fitness for the development of an individual exercise program. Your physical assessment may include cardiovascular and muscular fitness as well as flexibility, range of motion, core strength, and balance. In order to get a complete and appropriate individual assessment, it is imperative that you fill out this form completely and that you don't leave out any information that could influence your individual program.

Family history – check if any of your immediate family has had

Heart Disease () Mom () Dad () Grandfather () Grandmother () Brother/sister

Stroke () Mom () Dad () Grandfather () Grandmother () Brother/sister

Diabetes () Mom () Dad () Grandfather () Grandmother () Brother/sister

High blood pressure () Mom () Dad () Grandfather () Grandmother () Brother/sister

High cholesterol () Mom () Dad () Grandfather () Grandmother () Brother/sister

Other conditions/comments: _____

If there was a documented case of heart disease, please check the age category when they first knew.

() Under 50 years of age () Between 50-65 years of age () Over 65 years of age

Have any relatives died suddenly, without prior warning or knowledge of heart disease?

() Yes () No If yes, who? _____ Age at time of death? _____

Personal history – check if you have had:

AIDS() Anemia() Arthritis() Asthma() Bronchitis or emphysema()

Cancer() _____

If so, what kind? _____ Surgery (type and date) _____

Treatment (Treatment type and date) _____

Diabetes() Epilepsy() Gout() Heart disease() Heart murmur, skipped, or rapid beats()

High blood pressure() High cholesterol() Kidney disease() Lung disease()

Phlebitis() Rheumatic fever() Stroke() Thyroid problems()

Orthopedic injuries or chronic pain:

Neck() L shoulder() R shoulder() Cervical spine() Thoracic spine()
Lumbar spine()

L elbow() R elbow() L wrist() R wrist() L hip() R hip() L knee() R knee()

L ankle() R ankle() other()

Please explain any of the above that you have checked _____

Other conditions/comments _____

Medications:

Are you currently taking any prescription medications? ()Yes ()No If yes, what and how much?

Are you currently taking any over-the-counter medications or vitamins/supplements? ()Yes ()No If yes, what and how much?

Health habits:

Smoking history:

Do you smoke? ()Yes ()Quit ()Never

What do/did you smoke? ()Cigarettes ()Cigars ()Pipe

How much did/do you smoke a day? _____

How long have you been smoking? _____ If quit, when? _____

Exercise habits:

Do you engage in physical activity? ()Yes ()No

What kind? _____

How hard? ()Light ()Moderate ()Hard How often? _____

Did your past exercise habits differ from what you are doing now? ()Yes ()No

What kind of exercise have you done in the past? _____

How hard? ()Light ()Moderate ()Hard How often? _____

Is your occupation ()Sedentary ()Active ()Heavy work

Explain: _____

Do you experience discomfort, shortness of breath, or pain with exercise? ()Yes ()No

If yes, what type of exercise/symptoms? _____

Nutritional behavior:

Do you consider yourself overweight? ()Yes ()No

If yes, how long have you been overweight? _____

How many meals do you typically eat per day? _____

How often do you eat outside the home? _____ per week

How much of the following do you consume?

_____ cups of caffeinated coffee or tea per day

_____ glasses of caffeinated soda per day

_____ glasses of beer per day (12oz. = 1 unit)

_____ glasses of wine per day (4 oz. = 1 unit)

_____ glasses of liquor per day (1 1/2 oz. = 1 unit)

_____ units of alcohol per week (see above for unit equivalent)

Stress:

Do you consider your day stressful? ()Yes ()No

What is the nature of your stress? _____

How many hours do you sleep a night? _____ Is your sleep sound? ()Yes ()No

Do you practice any form of meditation? ()Yes ()No If so, what? _____