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 virtual 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 ag ( )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 murmer, 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 (11/2 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?_____