

HEALTH HISTORY QUESTIONNAIRE

Date _____

PERSONAL INFORMATION

Name _____

Date of Birth _____ Age _____

Phone (home) _____ (work) _____

E-Mail _____

Gender Male Female

PHYSICIAN INFORMATION

Please provide physician information below. According to the American College of Sports Medicine, it may be necessary to receive physician clearance prior to starting your exercise program.

Name _____

Address _____

Phone _____

SECTION 1

Check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Physician currently restricting activity level | <input type="checkbox"/> Chest discomfort with or without activity |
| <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Experience frequent light-headedness or fainting |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Shortness of breath while performing normal activities |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Currently pregnant or less than six weeks post-partum |
| <input type="checkbox"/> Palpitations or tachycardia | <input type="checkbox"/> History of cancer or lymphedema |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> History of stroke |
| <input type="checkbox"/> Pacemaker or AICD | <input type="checkbox"/> Hyper or hypothyroidism |
| <input type="checkbox"/> Coronary Angioplasty (PTCA) | <input type="checkbox"/> Diagnosed with diabetes |
| <input type="checkbox"/> Cardiac Catheterization | <input type="checkbox"/> Known abnormal blood sugar |
| <input type="checkbox"/> Heart attack | |
| <input type="checkbox"/> Bypass or other cardiac surgery | |
| <input type="checkbox"/> Currently taking medication for heart condition | |

If you checked any of the above statements in this section, consult your healthcare provider before engaging in exercise.

SECTION 2

Check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Female over 55 | <input type="checkbox"/> Diagnosed hypercholesterolemia (above 240mg/dl) |
| <input type="checkbox"/> Male over 45 | <input type="checkbox"/> Don't know cholesterol |
| <input type="checkbox"/> Premature menopause without hormone replacement therapy | <input type="checkbox"/> Current smoker |
| <input type="checkbox"/> Hysterectomy prior to menopause | <input type="checkbox"/> Former smoker—quit less than ten years ago |
| <input type="checkbox"/> Diagnosed hypertension (above 140/90) | <input type="checkbox"/> Currently 20 pounds over ideal weight |
| <input type="checkbox"/> Don't know resting blood pressure | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Currently taking blood pressure medication | |

Which of the following apply to your parents, brothers, or sisters?

- Heart attack or cardiac-related surgery prior to 50 years of age
- Stroke prior to 50 years of age

If you marked two or more statements in the above section, consult your healthcare provider before engaging in exercise.

SECTION 3

Check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Bone or joint condition aggravated by activity | <input type="checkbox"/> Migraine/headaches |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Swollen or stiff joints |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Infectious mononucleosis | <input type="checkbox"/> Foot problems |
| <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Knee problems |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Back problems |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Shoulder problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Abnormal chest x-ray | <input type="checkbox"/> Stomach or intestinal problems |
| <input type="checkbox"/> Increased anxiety | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Brain injury |
| <input type="checkbox"/> Unusual fatigue | <input type="checkbox"/> None of the above |

EXERCISE HISTORY

Are you presently exercising a minimum of three times per week at least 30 minutes at a time?

- Yes No

If yes, please specify:

- Running/jogging Racquet sports
 Brisk walking Cross-country skiing
 Biking Weight training
 Aerobic dancing Swimming

Other (please specify):

Total minutes engaged in aerobic activity per week:

- 0-20 minutes/week 61-80 minutes/week
 21-40 minutes/week 81-100 minutes/week
 41-60 minutes/week 101+ minutes/week

What are your goals for joining the LECOM Medical Fitness & Wellness Center?
(Please indicate all that apply.)

- Lose weight Improve cardiovascular fitness
 Improve flexibility Improve muscle conditioning
 Reduce lower back pain Reduce stress
 Stop cigarette smoking Lower cholesterol
 Improve nutrition Feel better overall

Other (please specify):

Check the description that best represents the amount of stress you experience on a daily basis.

- No stress Frequent high stress
 Occasional mild stress Constant stress
 Frequent moderate stress

Do you drink alcoholic beverages at all?

- Yes No

If yes, please specify:

- 0-2 drinks/week 3-14 drinks/week
 More than 14 drinks/week

NOTE: One drink equals one ounce of hard liquor, 6 oz. of wine, or 12 oz. of beer.

MEDICATIONS

Please list any medications you are currently taking and the reason:

ALLERGIES

Please list:

Current height _____ inches Current weight _____ pounds

Has your doctor referred you to the LECOM Medical Fitness & Wellness Center?

- Yes No

Have you participated in cardiac rehabilitation or physical therapy in the past 12 months?

- Yes No

If yes, for what reason

Exercise Physiologist Comments: