HEALTH HISTORY QUESTIONNAIRE

Last Name:_____________________________ First Name:_______________________________

Date: ____________________________ Sex M/F D.O.B._____/______/______

Age:_______ Weight:_____________ Height:_____________

Home Address: ____

City:_______________________________________ State: ______ Zip Code: ___________

Home Phone: ___________________________ Work Phone:_______________________________

Email address: ____

In case of emergency call: _____________________________________

Daytime Phone: _________________________ Evening Phone: _____________________

Please list your Physician's Name, Phone, and Address:

____

Please complete the following:

Part I: PAR Q YES NO

1. Have you ever been diagnosed with heart or cardiovascular disease? ❑ ❑

2. Do you ever have pain, pressure or squeezing sensation in your chest? ❑ ❑

3. Do you have a history or dizziness or fainting spells? ❑ ❑

4. Do you ever have shortness of breath at rest? ❑ ❑

5. Has a Physician ever said that your blood pressure was too high? ❑ ❑

6. Has a Physician ever told you that you have a bone or joint condition? ❑ ❑

Such as Arthritis that has been aggravated by exercise or might be made worse with exercise?

7. Is there a reason, that has not been mentioned above, that would limit ❑ ❑

your participation in an exercise program or activity in any way?

8. Are you over the age of 54 and /or unaccustomed to vigorous exercise? ❑ ❑

If you answered **YES** to any of the previous questions you must obtain clearance by your doctor before participating in an exercise program.

Part II: Coronary Risk Factors

YES NO

9. Do you have known elevated blood pressure (greater than 140/90) ❑ ❑

10. Do you have known elevated cholesterol levels? ❑ ❑

(Total/HDL Ratio greater than 5.0 or Total greater than 200 ML/dl)

11. Has a direct blood relative ever had heart disease prior to the age of 65? ❑ ❑

12. Do you have diabetes? ❑ ❑

If so, which type? TYPE I (insulin dependent) ______

TYPE II (adult onset) ____Age of onset: _____

13. Do you smoke? If YES, how many cigarettes, cigars, or pipes per day? _____ ❑ ❑

If you are an ex-smoker, when did you stop? ________

PART III: Cardiopulmonary or Metabolic Risk Factors

14. Do you have unaccustomed shortness of breath or shortness of breath with mild exertion? ❑ ❑

15. Do you often wake suddenly from sleep with difficulty breathing or (paroxysmal nocturnal dyspenea) ❑ ❑

16. Do you or ever experienced palpitations, tachycardia, arrhythmias, or irregular heartbeats? ❑ ❑

17. Do you have a history of heart murmur or valvular heart disease? ❑ ❑

18. Have you been diagnosed with an aortic aneurysm? ❑ ❑

19. Do you have any respiratory problems (i.e. Difficulty breathing, asthma, bronchitis, emphysema or re-occurring cough. ❑ ❑

20. Do you have any gastro/intestinal problems requiring ongoing treatment? ❑ ❑

PART IV   Other Risk Factors

21. Have you ever had any bone, muscle or joint condition, which ❑ ❑

might be aggravated by exercise? If Yes:

What type of injury/condition occurred and when?____

____

B. describe an medical treatment you received ____

____

C. do you have any symptoms or restrictions to this injury? ❑ ❑

22. Are you currently pregnant? ❑ ❑

IF yes what month are you in? __________________________________

Approximate due date of baby___________________________________

Please check the appropriate bow below for those, which may apply to you. (Past or Present)

❑Allergies
❑Anemia
❑Arthritis
❑Asthma
❑Bladder problems
❑Bronchitis
❑Broken bones

❑gout
❑kidney disease
❑Low back pain
❑Lung disease
❑Overweight
❑Phlebitis
❑Skin conditions

- ❑Cancer
- ❑Cirrhosis
- ❑COPD
- ❑Diabetes
- ❑Epilepsy or Seizures
- ❑Excessive Fatigue
- ❑Stroke
- ❑Thyroid problems
- ❑Ulcers
- ❑Nervous or emotional problems.
- ❑Poor tolerance for exercise
- ❑History of surgery

23. Do you have other chronic illnesses injury, or disabilities? If yes, please explain

____

____

____

24. Are you taking any medications, including aspirin, cold medicines, ❑ ❑

or herbal diet supplements? If yes, please explain:

Name of Med	Purpose	Dosage
____________	______________	________________
____________	______________	________________
____________	______________	________________
____________	______________	________________
____________	______________	________________

25. When was your last thorough physical examination? Date:___________

Results:____

26. Have you ever had a treadmill stress test or some other type of exercise test? ❑ ❑

If yes, what were the results? _______________________________

27. Rate your stress level: Low___ Average___ High___

28. Rate your nutritional habits: Good___ Average___ Poor____

PART V: Please complete the following sentences.

29. Do you currently exercise? If yes, please explain: ❑ ❑

Type Duration Sessions/Wk. Intensity (1-10)

____

____

____

30. What type of Aerobic Exercise have you done in the past?

____

____

31. Are you interested in: (please check all that apply)

Weight Loss: ____ Aerobic Conditioning:___

Weight gain:_____ Muscular Strength:_____

Smoking Cessation:_____ Muscular Endurance:______

32. How many days per week are you willing to exercise? ___________

33. The main reason(s) I want to exercise are:

1. ____
2. ____
3. ____

34. The primary obstacles that keep/have kept me from participating in a regular fitness program are/have been:

1. a.____
2. b. ____
3. c. ____