

# Health History Questionnaire

Answer each question by clearly printing your information. All information provided will be kept confidential. Should you have any questions or need assistance completing this questionnaire feel free to ask at any time. Complete all sections.

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
LAST FIRST MIDDLE MO DAY YR

**Address:** \_\_\_\_\_  
STREET APT NO. CITY STATE ZIP

**Home Phone:**( ) \_\_\_\_\_ - \_\_\_\_\_ **Work Phone:**( ) \_\_\_\_\_ - \_\_\_\_\_

**Other Phone:**( ) \_\_\_\_\_ - \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Physician:** \_\_\_\_\_

**Physician Address:** \_\_\_\_\_  
STREET SUITE NO. CITY STATE ZIP

**Physician Phone:**( ) \_\_\_\_\_ - \_\_\_\_\_

**In case of an Emergency Please Notify:**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
LAST FIRST MIDDLE

**Address:** \_\_\_\_\_ **Phone:**( ) \_\_\_\_\_ - \_\_\_\_\_  
STREET APT NO. CITY STATE ZIP

**1. Are you currently under the care of a physician, specialist, chiropractor, or other health care professional for any reason including chronic illness?  YES  NO**

**If yes, list reason:** \_\_\_\_\_

**Date of conditions onset:** \_\_\_\_\_ **Date of diagnosis:** \_\_\_\_\_

*Please take a moment to review all of your information to ensure it is accurate. Any changes are to be reported at the time of the change.*

2. Are you currently taking any medications?     YES     NO

If yes, please list:

Type	Dosage/Frequency	Reason for taking

3. Please list any allergies: \_\_\_\_\_

4. List any medications taken for allergies if any: \_\_\_\_\_

I am not aware of any disease or disorder that would complicate my participation in a testing or exercise program and/or nutritional advice, other than the medical conditions I have checked below:

NOTE: In order to assist you in the development of a rewarding physical fitness program, I need to have your honest and accurate responses.

1.  YES  NO ...Has your doctor ever told you that your blood pressure was too high?
2.  YES  NO ...Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise?
3.  YES  NO ...Are you over the age of 65?
4.  YES  NO ...Are you unaccustomed to vigorous exercise?
5.  YES  NO ...Is there any reason not mentioned here why you should not follow a regular exercise program? If so, state the reason:

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*Please take a moment to review all of your information to ensure it is accurate. Any changes are to be reported at the time of the change.*

*\* This form will be reviewed and discussed. All information provided or discussed is kept strictly confidential.*

6.    YES    NO ...Have you recently experienced any chest pain associated with exercise or stress?

7.    YES    NO ...Do you have –or- does your family have a history of any of the following conditions?

Heart Disease \_\_\_\_\_ Heart Attack \_\_\_\_\_

Hypertension \_\_\_\_\_ High Cholesterol \_\_\_\_\_

Gout \_\_\_\_\_ Angina \_\_\_\_\_

Abnormal EKG \_\_\_\_\_ Diabetes \_\_\_\_\_

Asthma \_\_\_\_\_ Other Heart Condition \_\_\_\_\_

Cancer \_\_\_\_\_ Parkinson's \_\_\_\_\_

Fibromyalgia \_\_\_\_\_ Multiple Sclerosis \_\_\_\_\_

8.    YES    NO ...Do you smoke? If so please select the choice that best describes your current habits:

- Non-user or Former user; date quit: \_\_\_\_\_
- Cigar and or pipe
- 15 or less cigarettes per day
- 16 to 25 cigarettes per day
- 26 to 35 cigarettes per day
- More than 35 cigarettes per day

**9. FAMILY HISTORY OF CARDIOVASCULAR (CV) DISEASE**

Please select the choice that best describes your personal family history

(Blood Relatives Only):

- No known history of heart disease
- One relative over age 60 with CV Disease
- Two relatives over age 60 with CV Disease
- One relative under age 60 with CV Disease
- Two relatives under age 60 with CV Disease
- Three relatives under age 60 with CV Disease

**10. MUSCULOSKELETAL**

Please describe any past or current musculoskeletal conditions you have incurred (i.e.: muscle pulls, sprains, fractures, surgery, back pain, or general discomfort).

Head/Neck \_\_\_\_\_ Upper Back \_\_\_\_\_  
Shoulder/Clavicle \_\_\_\_\_ Lower Back \_\_\_\_\_  
Arm/Wrist/Elbow/Hand \_\_\_\_\_ Hip/Pelvis \_\_\_\_\_  
Lower Leg/Ankle/Foot \_\_\_\_\_ Thigh/Knee \_\_\_\_\_

**11. NUTRITIONAL**

Are you on any specific diet, food/nutritional plan at this time?  YES  NO

If yes, please list \_\_\_\_\_

Do you take any dietary supplements?  YES  NO

If yes, please list \_\_\_\_\_

Do you experience any frequent weight fluctuations?  YES  NO

Have you experienced a recent weight gain or loss?  YES  NO

If yes, list change: I gained - \_\_\_\_\_ lbs. I lost - \_\_\_\_\_ lbs.

Over what period of time? \_\_\_\_\_

How many caffeine-containing beverages do you consume in an average day? \_\_\_\_\_  
 Soda  Tea  Coffee  Other(Please indicate): \_\_\_\_\_

**12. EXERCISE**

Please select the choice that best describes your work and exercise habits:

- Intense occupational & recreational exertion
- Moderate occupational & recreational exertion
- Sedentary work & intense recreational exertion
- Sedentary work & moderate recreational exertion
- Sedentary work & light recreational exertion
- Complete lack of all exertion basically inactive

**13. To what degree do you perceive your environments as stressful?**

Minimal  Moderate  Average  Extremely

Please make any other comments you feel are pertinent to you and your exercise program \_\_\_\_\_

*Please take a moment to review all of your information to ensure it is accurate. Any changes are to be reported at the time of the change, signed and dated.*

Member Name:(Print) \_\_\_\_\_ Date: \_\_\_\_\_

Member Signature: \_\_\_\_\_

Your signature verifies that you have truthfully and accurately completed this entire questionnaire. Thank you! If you have an email address please indicate here: \_\_\_\_\_.