HEALTH HISTORY QUESTIONNAIRE

Name: _____ Sex: M F Age: _____ Date: _____

Height: _____ Weight:_____ Date of Birth: _____

Physician: _____

ALLERGIES: _____

GENERAL MEDICAL HISTORY

1. Have you seen a Physician for a complete physical examination within the last year?..... YES NO
2. Have you been hospitalized or have you had major surgery within 1 year? YES NO
   Please specify:_____.
3. Do you have a history of any of the following conditions:
   - -Renal Disease/Failure?.....…… YES NO
   - -Liver Disease (Cholestasis, Cirrhosis or Hepatitis)? …… YES NO
   - -Thyroid Disorder? …… YES NO
   - -Bladder or bowel incontinence?……..… YES NO
   - -Neurological Disorders (i.e. epilepsy, stroke, MS, or parkinsons)?... YES NO
   - -Stroke …….. YES NO

Women's Health

4. Are you currently pregnant?..... YES NO
5. Have you given birth within the last 1 year?..... YES NO

CARDIAC DISEASE RISK FACTORS

6. Has a parent or siblings had a Heart Attack, Bypass Surgery, Diabetes, or other Heart Disease prior to **their** age of 55 (male) or age 65 (female)? YES NO
7. Do you presently smoke?..... YES NO
   a. If you are an ex-smoker, when did you stop? _____
8. Do you have Diabetes? ……. YES NO
   a. □ Type I Diabetes □ Type II Diabetes
9. Do you have Impaired Fasting Glucose? (fasting glucose of > 110 mg/dL) YES NO
10. Do you have high blood pressure? …… YES NO
    a. Do you take medicine to control your blood pressure? YES NO
11. Do you have high cholesterol (total >200 mg/dL or LDL >130 mg/ dL)? ..... YES NO
    ~~a. What is your HDL (Good) cholesterol? _____~~
    b. Do you take cholesterol lowering medication? YES NO
12. Do you experience dizziness/fainting at the sight of blood? ..... YES NO
13. Do you participate in regular physical activity? Regular physical activity includes a minimum of 30 minutes, 3 times a week, at moderate intensity (breathing heavily but can hold short conversations) over the last three months)?…… YES NO

CARDIOVASCULAR AND CIRCULATORY HISTORY

Have you had any of the following?

14.	Heart Attack	Date:.....……	YES	NO
15.	Congestive Heart Failure	Date:.....	YES	NO
16.	Angina or Chest Pain related to the heart	Date:.....	YES	NO
17.	Heart Bypass Surgery	Date:.....…….	YES	NO
18.	Heart Valve Surgery	Date:.....…..……	YES	NO
19.	Angioplasty (balloon, laser, roto rooter)	Date:.....	YES	NO
20.	Stent placement	Date: …….....	YES	NO
21.	Pacemaker	Date: ……	YES	NO
22.	Other surgery or problems related to your heart (explain)……		YES	NO
	……			

Have you had any of the following symptoms within the past 12 months?

23.	Pain or tightness in the chest, neck, shoulders, arms, or jaw.....	YES	NO
24.	"*Palpitations*" or "skipped beats" in your heart.....…	YES	NO
25.	Rapid heart rates at rest…….....…..	YES	NO
26.	Dizziness or fainting…….....….	YES	NO
27.	Swollen feet or ankles (Edema)…….....…	YES	NO
28.	Shortness of breath with rest or usual activities…..…….	YES	NO
29.	Severe pain in legs with usual activities …….	YES	NO
30.	Orthopnea/nocturnal Dyspnea ……	YES	NO
31.	Known heart murmur …….	YES	NO

32.	**Have you had a Stress Test (Treadmill) within the last year?**	YES	NO

If YES, **who** was the doctor that performed the test? _____
when was it done? _____
where was it done? _____

PULMONARY HISTORY

Have you been diagnosed with any of the following?

33.	Emphysema	YES	NO
34.	Chronic bronchitis (chronic cough & excessive sputum production)	YES	NO
35.	Chronic Obstructive Pulmonary Disease (COPD).……	YES	NO
36.	Asthma ……..	YES	NO
37.	Cystic Fibrosis ……	YES	NO

38.	Do you currently use "inhalants" for allergies or to breathe better?	YES	NO

Please specify:_____

39.	**Do you use oxygen at home**?.....	YES	NO

If *YES*, how much oxygen do you use? _____ (liters/minute)

CURRENT MEDICATIONS

40. Please list all medications you are taking or have recently taken:

Medication	*Dose*	*Reason*

MUSCULOSKELETAL HISTORY

41. Has a physician ever told you that you have a bone or joint problem that may be made worse with exercise?..... YES NO
    -Please Specify:_____
42. Have you ever had orthopedic surgery? (Date:.....) YES NO
    -Please Specify:_____
43. Are you or have you recently required physical therapy? (Date:.....) YES NO
    -Please Specify_____
44. Do you have a history of the following:
    - -Severe low back pain?..... YES NO
    - -Spinal Disc problems?..... YES NO
    - -Severely broken bones?..... YES NO
    - -Arthritis of the spine? ..... YES NO
    - -Degeneration of the Spine? ..... YES NO
    - -Osteoporosis? …… YES NO

OTHER MEDICAL HISTORY

45. Please list any other medical conditions or concerns that may affect your exercise program.

_____

_____

The information that is obtained during my participation in the _____ Program will be treated as privileged and confidential. It is not to be released or revealed to any person except my physician and/or insurer (s) without my written consent. The information obtained, however, may be used for statistical analysis or scientific purpose with my right to privacy retained.

I understand that accurate information about my health history is required to determine the safest most effective exercise program for me. I declare that information provided on this health history questionnaire is true and accurate to the best of my information, knowledge, and belief.

Signature: _____ Date: _____