**Health History Questionnaire**

Client name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_ Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_

Emergency contact person and contact information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic and contact information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last checkup and reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your current or usual occupation?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATIONS

What prescribed medications do you presently take? Why do you take them? Please write your dosage.

|  |  |  |
| --- | --- | --- |
| Medication | Dosage | Why taken |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

What non-prescription medicines (over the counter) do you take and why?

|  |  |  |
| --- | --- | --- |
| Over the counter medicine | Dosage | Why taken |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

ALLERGIES

Are you allergic to or have you had a “bad reaction” to any medicines or other substances?

* No
* If Yes, please list the medicine/substance and the reaction:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEALTH HABITS

Do you currently smoke cigarettes? ❒ No ❒ Yes \_\_\_\_\_ packs/day, \_\_\_\_\_# years

Have you ever smoked cigarettes? ❒ No ❒ Yes \_\_\_\_\_ packs/day, \_\_\_\_\_# years

When did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On the average, how many cups/cans of caffeine containing beverages do you consume per day?

\_\_\_\_\_ Tea \_\_\_\_\_ Coffee \_\_\_\_\_ Soda

On the average, how many alcoholic drinks do you have per day on weekdays? \_\_\_\_\_\_\_\_\_\_\_

on weekends? \_\_\_\_\_\_\_\_\_\_\_

Overall, how would you rate your diet? (Circle the appropriate number)

Unhealthy Healthy

1 2 3 4 5 6 7 8 9 10

PHYSICAL ACTIVITY HISTORY

Have you ever had an exercise test?

❒ No

❒ If yes:

Date of test \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If it was abnormal, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you aware of any physical limitation that would prevent you from exercising regularly?

❒ No

❒ If Yes, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently exercise on a regular basis?

❒ No

❒ If Yes, how many days per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long per session? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many months in a row have you exercised? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type(s) of exercise you enjoy doing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type(s) of exercise you do not enjoy doing or cause discomfort: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate your level of fitness?

❒ Poor ❒ Fair ❒ Average ❒ Above Average ❒ Excellent

How much time do you spend sitting or are sedentary during the day (approximately): \_\_\_\_\_\_\_\_\_ minutes

List some personal goals that you want to achieve in the program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERSONAL HISTORY

Check the box if you have ever had the following conditions:

|  |  |  |
| --- | --- | --- |
| **Current signs or symptoms suggestive of disease:** | Yes | When |
| Pain in the chest at rest or with exertion |  |  |
| Abnormal (palpitations) or fast heart beats |  |  |
| Heart murmur |  |  |
| Swelling of the calves, ankles and/or feet |  |  |
| Pain or cramping in the buttocks and/or lower legs with exertion |  |  |
| Dizziness or loss of consciousness (fainting spells) |  |  |
| Shortness of breath at rest or with exertion |  |  |
| Increasing or unexplained fatigue with normal activities or exercise |  |  |
| Shortness of breath laying down or at night |  |  |
|  |  |  |
| **Past medical conditions:** |  |  |
| Heart attack |  |  |
| Open heart surgery (e.g. bypass, valve, etc.) |  |  |
| Cardiac catheterization with or without angioplasty (stent) |  |  |
| Congenital heart disease |  |  |
| Heart failure |  |  |
| Heart murmurs |  |  |
| Stroke/Cerebrovascular disease |  |  |
| Pacemaker/Implantable cardiac defibrillator |  |  |
| Heart arrhythmia |  |  |
| Valve disease (aortic, mitral, etc.) |  |  |
| High blood pressure |  |  |
| Rheumatic fever |  |  |
| Thyroid disease |  |  |
| Diabetes mellitus (Type 1 or Type 2) |  |  |
| Kidney disease |  |  |
| Liver disease |  |  |
| COPD |  |  |
| Asthma |  |  |
| Chronic bronchitis |  |  |
| Emphysema |  |  |
| Osteoarthritis or Rheumatoid arthritis |  |  |
| Osteoporosis |  |  |
| Low back pain |  |  |
| Joint pain or swelling |  |  |
| Other orthopedic problems (bad knees/hips, etc.) |  |  |
| Emotional disorders |  |  |
| Anxiety |  |  |
| Depression |  |  |
| Other |  |  |
| Other condition not listed: |  |  |

If you answered yes to any of the above questions, please elaborate:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I hereby certify all statements provided by me in this questionnaire are complete and true to the best of my

knowledge. Further, I give my permission to the staff member to contact my personal physician or the

program’s medical director should there be questions or concerns about information in this health history

questionnaire form.

## Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_