



Health Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_
Address: \_\_\_\_\_
Home Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_
Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Level of activity: low, moderate, high
Marital Status: \_\_\_\_\_ Education level (highest attained): \_\_\_\_\_
Personal physician: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_
In case of emergency: \_\_\_\_\_ Relation: \_\_\_\_\_
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Part I - Symptoms:

- 1. Has your doctor ever said you have heart trouble, heart palpitation, coronary disease or high blood pressure: [ ] Yes [ ] No
2. Do you frequently experience pain or discomfort in the chest or heart area? [ ] Yes [ ] No
3. Do you suffer from shortness of breath at rest or upon mild exertion? [ ] Yes [ ] No
4. Do you suffer from dizziness or fainting? [ ] Yes [ ] No
5. Do you have any difficulty breathing? [ ] Yes [ ] No
6. Do you suffer from swollen ankles (due to circulation problems or metabolic condition?) [ ] Yes [ ] No

If "yes" is the answer to any of the above please have your physician complete a medical clearance form prior to exercise.

Part II - Risk Factors:

- 1. Has a physician ever diagnosed you as having high blood pressure (>160/90) or are you on blood pressure medication? [ ] Yes [ ] No
BP measurement: Right arm: \_\_\_\_\_ Left arm: \_\_\_\_\_ Average: \_\_\_\_\_
2. Your cholesterol is: \_\_\_\_\_ mg/dL (< 6 months ago.) Is the value >240mg/dL? [ ] Yes [ ] No
3. Do you smoke? [ ] Yes [ ] No If yes, how many cigarettes per day: \_\_\_\_\_
4. Do you suffer from diabetes? [ ] Yes [ ] No
5. Has anyone in your immediate family suffered from coronary or atherosclerotic disease prior to the age of 55? [ ] Yes [ ] No
6. Are you now or do you think you may be pregnant? [ ] Yes [ ] No

If "yes" is the answer to two or more of the above please have your physician complete a medical clearance form prior to exercise.

Medication/Limitations/Past Medical History:

List any medications (and doses) you are currently taking: \_\_\_\_\_
For what condition(s)? \_\_\_\_\_
Do you have any allergies? [ ] Yes [ ] No If so, what are they? \_\_\_\_\_
Do you have any physical limitations that would limit your ability to exercise? [ ] Yes [ ] No

EMAIL:

NAME:

If "yes" what are they? \_\_\_\_\_

List dates and reasons/outcomes of any past surgeries, abnormal test results, hospitalizations and/or treatments: \_\_\_\_\_

**Smoking/Physical Activity/Self Image:**

Did you ever smoke?  Yes  No If so, when did you start? \_\_\_\_\_ For how long? \_\_\_\_\_

Are you *now* smoke free?  Yes  No If so, how long? \_\_\_\_\_

If not, how many cigarettes per day? \_\_\_\_\_

Do you consider you lead a stressful life?  Yes  No

If so, rate from 1-10 (10 being the most stressful) \_\_\_\_\_

Do you practice stress management?  Yes  No

If so, how do you do it? \_\_\_\_\_

Do you participate in any kind of regular physical activity?  Yes  No

If so, how often? \_\_\_\_\_

What type of activities: \_\_\_\_\_

Do you consider yourself overweight, underweight or have no weight problem? \_\_\_\_\_

What do you consider a good weight for? \_\_\_\_\_ What is the most you ever weight? \_\_\_\_\_

What changes would you like to make in your body composition? \_\_\_\_\_

I pledge that all the information that I have provided in this form is accurate, to the best of my knowledge and that I have not willingly excluded any important medical information that could have any bearing on my ability to safely engage in exercise testing and exercise participation.

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_