Health History Questionnaire

Name: _____ Gender: M F Age: _____ DOB:__ /___/___

Address: _____

Phone #_____

Person to contact in case of emergency: _____
Phone #_____ Relationship to you: _____

Personal Physician: _____ Location: _____
Phone #_____

Please provide the following information as accurately and completely as possible.

KNOWN CARDIOVASCULAR, PULMONARY OR METABOLIC DISEASE

Have you been diagnosed with any of the following diseases/disorders/conditions or undergone any of the following procedures? If yes, please explain.

☐ Yes ☐ No Myocardial Infarction ("heart attack")_____
☐ Yes ☐ No Stroke or ischemic attack ("mini stroke")_____
☐ Yes ☐ No Peripheral Vascular Disease_____
☐ Yes ☐ No Heart surgery_____
☐ Yes ☐ No Coronary catheterization and/or angioplasty_____
☐ Yes ☐ No Abnormal ECG (tachycardia, heart block, etc.)_____
☐ Yes ☐ No Other cardiovascular disease/disorder_____
☐ Yes ☐ No Lung disease (COPD, asthma, cystic fibrosis, etc.)_____
☐ Yes ☐ No Diabetes (Type I or II)_____
☐ Yes ☐ No Thyroid Disorders_____
☐ Yes ☐ No Renal or liver disease_____

SIGNS OR SYMPTOMS OF CARDIOVASCULAR OR PULMONARY DISEASE

Have you experienced any of the following? If yes, please explain.

☐ Yes ☐ No Pain/discomfort in chest, jaw, or arms_____
☐ Yes ☐ No Shortness of breath at rest or mild exertion_____
☐ Yes ☐ No Dizziness or fainting spells_____
☐ Yes ☐ No Difficulty breathing while lying down_____
☐ Yes ☐ No Swelling of your ankles_____
☐ Yes ☐ No Skipped heartbeats or a racing heartbeat_____
☐ Yes ☐ No Severe leg pain, especially while walking_____
☐ Yes ☐ No Heart murmur_____
☐ Yes ☐ No Fatigue or shortness of breath with usual activities_____

RISK FACTORS OF CARDIOVASCULAR DISEASE

Do you have a personal history of any of the following? If yes, please explain.

☐ Yes ☐ No Cigarette smoking: Current smoker or quit within last 6 months (y/n)? ____
Years smoked_____? Number of cigarettes per day? _____

☐ Yes ☐ No Family history of heart attack, heart surgery, or sudden death at a young age: Age_____ Relation to you:_____

☐ Yes ☐ No High Blood Pressure (≥140 and/or ≥ 90)_____

☐ Yes ☐ No High Cholesterol (total >200, LDL >130, HDL <40 mg/dl)_____

☐ Yes ☐ No Diabetes or high fasting blood glucose (≥100mg/dl)_____

☐ Yes ☐ No Obese or highly overweight_____

☐ Yes ☐ No Sedentary lifestyle (not active for 30 min most days)_____

DRUGS/MEDICATIONS

Please list any prescription or over-the-counter drugs/medications you are currently taking.

Drug / Medication	Purpose / Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____

ADDITIONAL QUESTIONS

Are you currently suffering from any illness? Yes ___ No ___
If yes, _____
_____

If female, are you pregnant? Yes ___ No ___
Do you have any current injuries or pain that might limit your physical activity? Yes ___ No ___
If yes, _____
_____

Do you know of any other reason why you should not do physical activity? Yes ___ No ___
If yes, _____
_____

Staff Notes: _____
_____
_____
_____
_____

ACSM Risk Classification _____

Plan of Action: _____

_____ _____ _____
(Staff Name) (Staff Signature) (Date)