



Health Questionnaire

First Name _____ Last Name _____ M/F _____ Today's Date ____/____/____

DOB ____/____/____ Age _____ Mobile: (____) _____ - _____ Home Phone (____) _____ - _____

Work Phone (____) _____ - _____ Fax: (____) _____ - _____ E-mail Address: _____

Address _____

Emergency Contact Name _____ Relationship _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____ Mobile (____) _____ - _____

Primary Care Physician _____ Phone Number: (____) _____ - _____

Other _____ Phone Number: (____) _____ - _____

Other _____ Phone Number: (____) _____ - _____

Medical History (Please Check Only Those That Apply)

Known Diseases

- Any personal history of coronary or atherosclerotic disease?
- Any personal history of diabetes or other metabolic disease (thyroid, renal, liver)?
- Any personal history of pulmonary, asthma, or any other lung disease?

Suggestive Symptoms

- Have you experienced pain, discomfort, or other anginal equivalents in your chest, neck, jaw, arms, or other areas resulting from a restriction in blood supply?
- Any unaccustomed shortness of breath at rest with mild exertion or during light exercise?
- Have you had any problems with dizziness or fainting?
- Do you have difficulty breathing that occurs at rest in the recumbent position or during sleep that is relieved promptly by sitting upright or standing?
- Do you suffer from swelling of the ankles?
- Have you experienced a rapid throbbing or fluttering of the heart?
- Do you suffer from severe pain in the leg muscles during walking as a result of inadequate blood supply?
- Do you have a known heart murmur?
- Do you experience unusual fatigue or shortness of breath with usual activities?

Coronary Risk Factors

- Are you a man ≥ 45 years of Age?
- Are you a woman ≥ 55 years of age? **OR** Have you had a hysterectomy? **OR** Are you postmenopausal? **OR** Do you have premature menopause without estrogen replacement therapy?
- Are you physically inactive (You get < 30 minutes of moderate physical activity on at least 3 days per week)?
- Are you a current cigarette smoker or have you recently quit in the past 6 months?
- LDL cholesterol > 130 **OR** HDL < 40 **OR** Are you on lipid-lowering medication? **OR** Is your total serum cholesterol > 200 mg/dl?
- Fasting Blood Glucose ≥ 100 confirmed on at least 2 separate occasions?
- BMI > 30 **OR** Waist Girth > 102 cm for men and > 88 cm for women **OR** waist/hip ratio ≥ 0.95 for men and ≥ 0.86 for women.
- Do you have any family history of coronary or atherosclerotic disease, or sudden death in your father or brother prior to age 55, or before 65 years of age in your mother or sister.
- Do you have high blood pressure (Systolic blood pressure ≥ 140 or Diastolic ≥ 90) that has been confirmed on at least 2 separate occasions or are you on blood pressure medications?



Do you know of any other disease, physical or medical condition, illness, surgery, or any other reason why you should not participate in an exercise program? Yes / No **If yes, please explain.**

Please explain any orthopedic surgeries that you have had

Do you have any injuries (bone or muscle disabilities) that may interfere with exercising? Yes / No **If yes, please explain.**

Please list any medications you are currently taking

Medication	Dosage	Frequency	Reason for Medication
-------------------	---------------	------------------	------------------------------

<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>

Activity or Sport Participation

Have you ever followed a structured training plan? Yes / No **If yes, please describe your most recent workout routine.**

Other Comments

Participant Signature

Print Name

Date

Parent / Guardian Signature (If under 18 yrs of age)

Print Name

Date

Witness Signature

Print Name

Date