Health History Questionnaire

Demographic Information Date_____

Name: _____ Email Address: _____

Address: _____ City/State/Zip: _____

Telephone: (Home) _____ (Work): _____

Date of Birth: _____ Age: _____ Gender: _____

Personal Medical History

Height_____ Weight_____ Desired Weight_____

Personal Physician_____ Specialty_____

Address: _____ Phone: _____

Current Medications (Prescription, Non-Prescription, & Supplements)	
Name of medication	Reason

Are you allergic to any medications? No___ Yes___

If yes, please list: _____

In case of emergency, contact: _____ Phone: _____

Alternate emergency contact: _____ Phone: _____

Hospitalization: List recent hospitalizations (except normal pregnancies)	
Date:	Reason:
Date:	Reason:
Date:	Reason:

Any other medical concerns or problems not already identified? No___ Yes___

If yes, please list. _____

Are you currently following a weight reduction diet program? No___ Yes___

If yes, for how long and what type of program?

_____

Overall, how "stressed" do you feel? □very little □fairly □somewhat □a lot □extremely

Why do you want to join an exercise program?

□ Lose weight □ For better health □ Reduce stress □ Enjoyment

□ Improve appearance □ Doctor's recommendation □ Other_____

Do you currently smoke? No___ Yes___ If yes, how many packs per day?_____

Females Only: Are you □ Pre-menopause □ Peri-menopause □ Post menopause (at age___yrs)

Hormonal therapy? □ Currently (list drug under medications above) □ Past (for how long?____)

Currently pregnant? ____No ____Yes

Updated Aug 2019

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Personal Health History

Have you ever had, or been told that you have…?

	No	Yes
High blood pressure	☐	☐
High cholesterol	☐	☐
Diabetes	☐	☐
Renal Disease	☐	☐
Heart attack	☐	☐
Stroke	☐	☐
Angina/chest pain	☐	☐
Artery disease	☐	☐
Heart murmur	☐	☐
Any heart surgery	☐	☐
Any heart trouble	☐	☐
Pacemaker/implantable cardiac defibrillator	☐	☐
Varicose veins	☐	☐
Asthma/Bronchitis	☐	☐
Irregular Heart Beat	☐	☐
Arthritis/joint pain	☐	☐
Back pain/injury	☐	☐
Joint/muscle swelling	☐	☐
Emphysema	☐	☐
Osteoporosis	☐	☐
Cancer	☐	☐
Anemia	☐	☐
Phlebitis or emboli	☐	☐
PVD	☐	☐
Light-headedness	☐	☐
Fainting	☐	☐
Shortness of breath	☐	☐
Hiatal Hernia	☐	☐
Alzheimer's/Dementia	☐	☐

Updated Aug 2019

Physical Activity

How would you rate your occupational activity level?

☐ Sedentary ☐ Light ☐ Moderate ☐ Heavy

Over the past 3 months have you performed regularly in aerobic physical activities such as brisk walking, jogging, swimming, aerobic dance, bicycling, etc.?___No ___Yes

If yes, what type? _____

_____

How many days per week?____days per week.

How many minutes per day?____ minutes per day.

Please circle how you perceive the overall effort of your body during exercise?

Very, very light Very light Fairly light
Somewhat hard Hard Very hard
Very, very hard

Do you ever have uncomfortable shortness of breath during exercise? ____No ____Yes

Do you ever have chest or any other discomfort during exercise? No Yes

Family Health History

Have any immediate family or grandparents had?

	No	Yes
Heart attack	☐	☐
Angina/Chest Pain	☐	☐
Any heart surgery	☐	☐
Heart Disease	☐	☐
High blood pressure	☐	☐
High Cholesterol	☐	☐
Diabetes	☐	☐
Stroke	☐	☐
Sudden death	☐	☐
Cancer	☐	☐

Present or Recent Signs/Symptoms

	No	Yes
Chest pain/discomfort	☐	☐
Pain in jaw, neck arms or shoulder blades		
Shortness of breath	☐	☐
Dizziness	☐	☐
Rapid heartbeats	☐	☐
Skipped heart beats	☐	☐
Heart murmur	☐	☐
Intermittent claudication	☐	☐
Ankle swelling (not injury-related)	☐	☐
Nocturnal dyspnea/ orthopnea	☐	☐
Frequent headaches	☐	☐
Blood in urine or stools	☐	☐
Coughing on exertion	☐	☐
Coughing of blood	☐	☐