Health History Questionnaire

Name: _____ DOB: _____ Age: _____ Gender: _____

Current Weight: _____ Height: _____

Phone Number: _____ Email: _____

PAR-Q

Yes **No**

- ☐ ☐ Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
- ☐ ☐ Do you feel pain in your chest when you do physical activity?
- ☐ ☐ In the past month, have you had chest pain when you were not doing physical activity?
- ☐ ☐ Do you lose your balance because of dizziness or do you ever lose consciousness?
- ☐ ☐ Do you have bone or joint problems (for example, back, knee, or hip) that could be made worse by a change in your physical activity?
- ☐ ☐ Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
- ☐ ☐ Do you know of any other reason why you should not do physical activity?

Health Questions

Assess your health status by marking all true statements.

1. **YOU HAVE HAD:**

Myocardial Infarction (Heart Attack)	☐ YES	☐ NO
Coronary Artery Disease	☐ YES	☐ NO
Congestive Heart Disease	☐ YES	☐ NO
Congenital Heart Disease	☐ YES	☐ NO
Pacemaker	☐ YES	☐ NO
Arrhythmia's (extra, skipped, or rapid heart beats)	☐ YES	☐ NO
Mitral Valve Prolapse	☐ YES	☐ NO

Please explain any 'YES' response

_____

_____

2. PLEASE CIRCLE IF IN THE LAST YEAR, YOU'VE EXPERIENCED THE FOLLOWING:

Chest discomfort with exertion	☐ YES	☐ NO
Shortness of breath at rest with mild exertion	☐ YES	☐ NO
Orthopnea or paroxysmal nocturnal dyspnea	☐ YES	☐ NO
Dizziness, fainting, or blackouts	☐ YES	☐ NO

3. SURGICAL PROCUDRES YOU HAVE HAD

Angioplasty (PTCA)	☐ YES	☐ NO
Heart Catherization	☐ YES	☐ NO
Coronary Artery Bypass (CABG)	☐ YES	☐ NO
Valve Replacement	☐ YES	☐ NO

Please explain 'YES' or describe **ANY other surgical procedures**.

_____

_____

_____

4. PLEASE INDICATE IF YOU HAVE BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS:

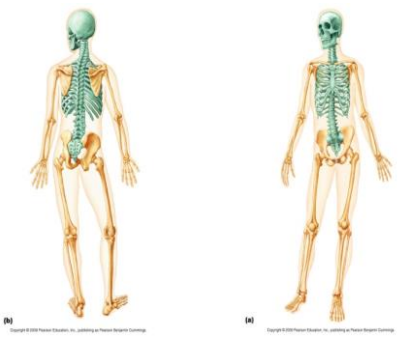
High Cholesterol (above 240mg/dl) within the last 6 months	☐ YES	☐ NO
Diabetes Mellitus	☐ YES	☐ NO
Renal Disorder	☐ YES	☐ NO
Thyroid Disorder	☐ YES	☐ NO
Liver Disease	☐ YES	☐ NO
Pain/Discomfort in chest surrounding areas (Angina)	☐ YES	☐ NO
Shortness of breath with or without exertion	☐ YES	☐ NO
Orthopnea/Paroxysmal Nocturnal Dyspnea (Attacks respiratory distress)	☐ YES	☐ NO
Ankle Edema (swelling) or Leg Cramps	☐ YES	☐ NO
Palpitations or Tachycardia (rapid heart beat)	☐ YES	☐ NO
Claudication (leg cramps/blocakage in extremities)	☐ YES	☐ NO
Known Heart Murmur	☐ YES	☐ NO
Osteopenia or Osteoperosis	☐ YES	☐ NO

5. **ORTHOPEDIC:** Please list and identify (by circling) ALL current or previous orthopedic (back, neck, shoulder, knee) problems.

_____

_____

_____



6. **MEDICATIONS:** Please list ALL prescription and over-the counter medications and supplements.

_____

_____

_____

7. **ALLERGIES:** Pleast list all alergies.

_____

_____

_____

Lifestyle Questions

8. **What is your occupation AND please describe the activity level associated with your job in a given day.**

_____

_____

_____

9. **Are you currently involved in an exercise OR nutrition program?**

If so please elaborate: _____

a. If you do exercise currently, please describe a typical weekly routine with types of exercises and amount of time per day on the chart below. For Resistance Training use RT, for Cardiovascular Training use CT, and for all other, please describe.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

a. How many days of the week would you realistically like to exercise?_____

b. What time of the day would be best for you to exercise? _____

c. Please list which days of the week are the best for you to exercise_____

10. **Please check the box that best describes the last time that you were involved in an exercise program?**

☐ 0-6 months ☐ 6 months-1year ☐ 1-2 years ☐ 2-3years ☐ 4-5years ☐ 5+years

11. Please check the number that best represents your lifestyle?

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Sedentary Somewhat Active Very Active

12. Do you currently smoke or use tobacco products?

☐ No, I have never ☐ No, I quit ___ months ago ☐ Yes, I currently use

13. Do you currently consume alcoholic beverages?

☐ No, I do not ☐ Yes, I consume alcohol____ days per week, ____ drinks per day

14. Do you currently consume caffeine?

☐ No, I do not ☐ Yes, I consume_____

Coffee/Tea/Soda Cups/Drinks per day OR mg/day

15. How many glasses of water (~8 oz. glasses) do you drink per day?

☐ I don't drink water ☐ 1 glass ☐ 2-3 glasses

☐ 4-6 glasses ☐ 7-8 glasses ☐ >8 glasses

16. How many hours of sleep do you get per night?

☐ <5 ☐ 5-6 ☐ 7-8 ☐ 8-9 ☐ >9

17. What are your primary health and fitness goals?

☐ Weight loss ☐ Injury Prevention ☐ Improve Flexibility

☐ Build Muscle ☐ Gain Mass ☐ Increase Muscle Tone ☐ Muscle Endurance

☐ Build Curves ☐ Increase Strength ☐ Increase Fitness ☐ Other (Please List)_____

a. Do you have a specific goal and timeline for achieving that goal? If so, please specify:

_____

_____

_____

18. What is your biggest obstacle(s) to attaining your fitness goals?

☐ Lack of Time ☐ Lack of Motivation ☐ Lack of Interest ☐ Lack of Results

☐ Fear of Injury ☐ Lack of Support ☐ Lack of Knowledge ☐ Inconvenience