Health History Questionnaire

Please answer the following questions to the best of your ability. For the following questions, unless otherwise indicated, circle the single best choice for each question. As is customary, all of your responses are completely confidential. If you have any physical handicaps or limitations that would require special assistance with this questionnaire, please let your trainer know. This form is in accordance with the American College of Sports Medicine guidelines for risk stratification when followed correctly by your coach.

Name: _____ Ht: _____ Wt: _____

Gender: _____ Age: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Personal Physician: _____ Phone: _____

E-mail: _____

1. Have you ever had a definite or suspected heart attack or stroke? ……..…….Yes No
2. Have you ever had coronary bypass surgery or any other type of heart surgery?…..…Yes No
3. Do you have any other cardiovascular or pulmonary (lung) disease (***other than*** asthma, allergies, or mitral valve prolapse)? ……..…… Yes No
4. Do you have a history of: diabetes, thyroid, kidney, liver disease? ..…….……Yes No **(circle all that apply)**
5. Have you ever been told by a health professional that you have had an abnormal resting or exercise (treadmill) electrocardiogram (EKG)? ……..……..…… Yes No
6. If you answered YES to any of Questions 1 through 5, please describe:

_____

_____

_____

_____

1. Do you currently have any of the following:
   a. Pain or discomfort in the chest or surrounding areas that occurs when you engage in physical activity ……..……..…….Yes No
   b. Shortness of breath ……..……..……..…Yes No
   c. Unexplained dizziness or fainting ….……..……..…Yes No
   d. Difficulty breathing at night except in upright position ……..……..…Yes No
   e. Swelling of the ankles (recurrent and unrelated to injury) ……..……..…Yes No

f. Heart palpitations (irregularity or racing of the heart on more then one occasion) ...Yes No
g. Pain in the legs that causes you to stop walking (claudication) …..……Yes No
h. Known heart murmur …..……..……..…….Yes No

Have you discussed any of the above with your personal Physician? ……..……Yes No

1. Are you pregnant or is it likely that you could be pregnant at this time? …..……Yes No
   If yes, what is your expected due date?_____
2. Have you had surgery or been diagnosed with any disease in the past 3 months? ……Yes No
   If yes, please list date _____ and surgery/disease _____
3. Have you had high blood cholesterol or abnormal lipids within the past 12 months
   or are you taking medication to control your lipids? ……..….Yes No
4. Do you currently smoke cigarettes or have quit within the past 6 months? ……..Yes No
5. Have you father or brother(s) had heart disease prior to age 55 OR
   mother or sister(s) had heart disease prior to age 65? ……..…..Yes No
6. Within the past 12 months, has a health professional told you that you
   have high blood pressure (systolic ≥ 140 OR diastolic ≥ 90)? ……..…..Yes No
7. Currently, do you have high blood pressure or within the past 12 months,
   have you taken any medicines to control your blood pressure? ……..…..Yes No
8. Have you ever been told by a health professional that you have a fasting
   blood glucose greater than or equal to 110 mg/dl? ……..…..Yes No
9. Describe your regular physical activity or exercise program:
   type: _____
   frequency: _____ days per week
   duration: _____ minutes
   intensity: *low* *moderate* *high* *(circle one)*
10. If you have answered YES to any of questions 7-16, please describe:

_____

_____

_____

1. Are you currently under any treatment for any blood clots? ……..…..Yes No
2. Do you have problems with bones, joints, or muscles that may be aggravated with exercise? Yes No
3. Do you have any back/neck problems? ……..……..…..Yes No
4. Have you been told by a health professional that you should not exercise? ……..Yes No
5. Are you currently being treated for any other medical condition by a physician? …….Yes No
6. Are there any other conditions (mitral valve prolapse, epilepsy, history of rheumatic fever,
   asthma, cancer, anemia, hepatitis, etc.) that may *hinder* your ability to exercise? ……Yes No
7. During the past six months, have you experienced any *unexplained* weight loss
   or gain (greater than ten pounds for no known reason)? ……..….Yes No
8. If you have answer YES to any of questions 18-24, please describe:

_____

_____

_____

1. Please list below all prescription and over-the-counter medications you are currently taking:
1. Are there any medicines that your physician has prescribed to you in the past 12 months which you are currently
   not taking? ……..…..Yes No

If so, please list:

_____

_____

I have answered the Health History Questionnaire questions accurately and completely. I understand that my medical history is a very important factor in the development of my coaching program. I understand that certain medical or physical conditions which are known to me, but that I do not disclose to my coach may result in serious injury to me. If any of the above conditions change, I will immediately inform my coach of those changes. I, knowingly and willingly, assume all risks of injury resulting from my failure to disclose accurate, complete, and updated information in accordance with the attached questionnaire.

Client's Signature: _____ Date: _____

Coach's Signature: _____ Date: _____

For Use by the Coach ONLY

Check the identified ACSM major coronary risk factors below:

_____ Lipids (TCH ≥ 200 OR HDL < 35)
_____ Family History
_____ Diabetes/glucose ≥110 mg/dl
_____ BMI ≥ 30
_____ Metabolic Disease
    _____ Signs or Symptoms of Cardiovascular Disease
_____ Cardiovascular Disease
    _____ Cigarette Smoking (or quit within the past 6 months)
    _____ High Blood Pressure/ Blood Pressure Medications
    _____ Sedentary
    _____ Pregnancy
    _____ Respiratory Disease (asthma, emphysema, chronic bronchitis).

All clients needing written medical clearance from their personal physician must give it to their coach prior to beginning their exercise program

Health History Questionnaire follows the American College of Sports Medicine recommendations for risk stratification. This must be performed on all clients in order to determine the need for medical clearance and/or exercise modifications.
If a client has a YES response to anything on page 1, he/she has KNOWN DISEASE, and must have medical clearance prior to beginning exercise.
If he/she has a YES response to anything on #7 a-h on page 2, your client is HIGH RISK WITH SIGNS/SYMPTOMS and must have medical clearance prior to exercise. If your client has a YES response to questions #8 or 9, he/she must have medical clearance.
YES responses to two or more on questions 10-16 on page 2, your client is HIGH RISK WITHOUT SIGNS OR SYMPTOMS and must have medical clearance (unless he/she also has a YES answer in question #7 making them still HIGH RISK WITH SIGNS/SYMPTOMS).
All other questions on page 3 are at your own discretion. Remember, **when in doubt, refer out.**