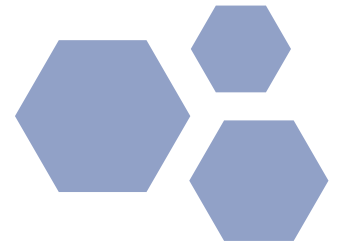




HEALTH-HISTORY QUESTIONNAIRE



Name: _____ Phone (H): _____

Address: _____

City: _____ ZIP: _____

Emergency Contact: _____ Emergency Phone: _____

Personal Physician: _____

DOB: _____ Age: _____ Sex: M F Physician's Phone: _____

SECTION I. MEDICAL HISTORY

1. Mark any of the following for which you have been diagnosed or treated:

- | | | | |
|---|---|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Kidney problem | <input type="checkbox"/> Heart problem | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Cirrhosis, liver | <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma |

2. Mark any medications taken in the last 6 months:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Blood thinner | <input type="checkbox"/> Epilepsy medicine | <input type="checkbox"/> Nitroglycerin | <input type="checkbox"/> Cholesterol medicine |
| <input type="checkbox"/> Diabetes medicine | <input type="checkbox"/> Heart rhythm medicine | <input type="checkbox"/> Insulin | <input type="checkbox"/> Other |
| <input type="checkbox"/> Blood pressure medicine | <input type="checkbox"/> Diuretic (water pill) | <input type="checkbox"/> Digitalis | |

3. List any surgeries you have had in the past (e.g., knee, heart, or back):

4. Have you ever had back problems, any problems with joints (knee, hip, shoulder, elbow, or neck), or been diagnosed with arthritis? _____ If yes, describe:

5. Do you have any other medical conditions or health problems that may affect your exercise plan or safety in any way? _____ If yes, describe:

SECTION II. CARDIOPULMONARY AND METABOLIC SYMPTOMS

YES NO

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you ever get unusually short of breath with very light exertion? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you ever have pain, pressure, heaviness, or tightness in the chest area? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you regularly have unexplained pain in the abdomen, shoulder, or arm? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you ever have dizzy spells or episodes of fainting? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you ever feel "skips," palpitations, or runs of fast or slow heartbeats in your chest? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has a physician ever told you that you have a heart murmur? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you regularly get lower-leg pain during walking that is relieved with rest? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any joints that often become swollen and painful? Where: _____ |

SECTION III. CARDIOPULMONARY/METABOLIC DISEASE

YES NO Have you ever had a heart attack, bypass surgery, angioplasty, or been diagnosed with coronary artery disease or other heart disease?
If yes, describe:

YES NO Do you have emphysema, asthma, or any other chronic lung condition or disease?

YES NO Are you an insulin-dependent diabetic?

SECTION IV. CORONARY RISK FACTOR PROFILE

YES NO Have you had high blood pressure (≥ 140 mmHg systolic or ≥ 90 mmHg diastolic) on more than one occasion?

Please list any medications you take for high blood pressure:

YES NO Have you ever been told that your blood cholesterol was high (200 mg/dL or higher)?
Cholesterol level _____

YES NO Do you currently smoke 10 or more cigarettes per day?
cigarettes/day _____ years smoked _____

YES NO Have you ever been told that you have high blood sugar or diabetes? If yes, describe:

YES NO Has anyone in your immediate family (parents and siblings) had any heart problems or coronary disease before age 55? If yes, describe:

YES NO Do you feel you are more than 20 lb (9 kg) overweight?
What do you feel is your realistic ideal weight? _____

SECTION V. FITNESS

Circle the average number of times per week you participate in planned moderate-to-strenuous exercise of at least 20 minutes duration (e.g., brisk walking, jogging, cycling, swimming, stair climbing, weightlifting, active sports such as tennis, or aerobic classes).

0 1 2 3 4 5 6 7 8 9 10

YES NO Can you briskly walk 1 mile without fatigue?

YES NO Can you jog 2 miles continuously at a moderate pace without discomfort?

YES NO Can you do 20 push-ups?

Please list your body weight (circle the appropriate units):

Now: _____ lb/kg 1 year ago: _____ lb/kg Age 21: _____ lb/kg

SECTION VI. LIFESTYLE AND BEHAVIORAL

1. Describe any aerobic exercise you have done in the past (what, when, how often, and for how long). _____

2. Describe any muscular strength/weight training you have done in the past (what, when, how often, and for how long). _____

3. List any major obstacles that you feel you will have to overcome to stick with your exercise plan long-term (e.g., what has stopped you in the past).

4. Have you ever participated in aerobic or aerobic step classes? Yes No

5. Please list any recreational physical activities (e.g., tennis or golf) in which you regularly participate and how often.

6. List any favorite activities you would like to include in your exercise plan. _____

7. List any activities that you definitely do not like and do not want to include. _____

8. Which do you prefer? Group exercise Exercising on your own

9. List the two most important goals or reasons why you want to exercise regularly. _____

10. Your occupation: _____

11. Do you spend more than 25% of work time doing the following (mark all that apply)?

Sitting at a desk Lifting/carrying loads Standing Driving Walking

12. Number of hours worked per week: _____ Hours Any flexible hours? Yes No

13. Write in the best exercise times for you during a typical week.

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
AM							
PM							

14. Where do you plan to exercise? Club Home Outside

Other _____

15. If at home, list all available equipment.

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