

HEALTH STATUS QUESTIONNAIRE

SECTION ONE - GENERAL INFORMATION

1. Date _____
2. Name _____
3. Mailing Address _____ Phone (H) _____
_____ Phone (W) _____
Email _____
4. *EI* Personal Physician _____ Phone _____
Physician Address _____ Fax _____

5. *EI* Person to contact in case of emergency _____ Phone _____
6. Gender (circle one): Female Male *RF*
7. *RF* Date of birth _____ / _____ / _____
8. Height _____ Weight _____
9. Number of hours worked per week: Less than 20 20-40 41-60 over 60
10. *SLA* More than 25% of the time at your job is spent (circle all that apply)
Sitting at desk Lifting loads Standing Walking Driving

SECTION TWO - CURRENT MEDICAL INFORMATION

11. Date of last medical physical exam: _____
12. Circle all medicine taken or prescribed in last 6 months:

Blood thinner <i>MC</i>	Epilepsy medication <i>SEP</i>	Nitroglycerin <i>MC</i>
Diabetic <i>MC</i>	Heart rhythm medication <i>MC</i>	Other _____
Digitalis <i>MC</i>	High blood pressure medication <i>MC</i>	
Diuretic <i>MC</i>	Insulin <i>MC</i>	
13. Please list any orthopedic conditions. Include any injuries in the last six months

14. Any of these health symptoms that occur frequently (two or more times/month) requires medical attention. Please check any that apply.

- | | |
|--|--|
| a. <input type="checkbox"/> Cough up blood <i>MC</i> | g. <input type="checkbox"/> Swollen joints <i>MC</i> |
| b. <input type="checkbox"/> Abdominal pain <i>MC</i> | h. <input type="checkbox"/> Feel faint <i>MC</i> |
| c. <input type="checkbox"/> Low-back pain <i>MC</i> | i. <input type="checkbox"/> Dizziness <i>MC</i> |
| d. <input type="checkbox"/> Leg Pain <i>MC</i> | j. <input type="checkbox"/> Breathlessness with slight exertion <i>MC</i> |
| e. <input type="checkbox"/> Arm or shoulder pain <i>MC</i> | k. <input type="checkbox"/> Palpitation or fast heart beat <i>MC</i> |
| f. <input type="checkbox"/> Chest pain <i>RF MC</i> | l. <input type="checkbox"/> Unusual fatigue with normal activity <i>MC</i> |
| Other _____ | |

SECTION THREE - MEDICAL HISTORY

15. Please circle any of the following for which you have been diagnosed or treated by a physician or health professional:

Alcoholism <i>SEP</i>	Diabetes <i>SEP</i>	Kidney problem <i>MC</i>
Anemia, sickle cell <i>SEP</i>	Emphysema <i>SEP</i>	Mental illness <i>SEP</i>
Anemia, other <i>SEP</i>	Epilepsy <i>SEP</i>	Neck strain <i>SLA</i>
Asthma <i>SEP</i>	Eye problems <i>SLA</i>	Obesity <i>RF</i>
Back strain <i>SLA</i>	Gout <i>SLA</i>	Phlebitis <i>MC</i>
Bleeding trait <i>SEP</i>	Hearing loss <i>SLA</i>	Rheumatoid arthritis <i>SLA</i>
Bronchitis, chronic <i>SEP</i>	Heart problems <i>MC</i>	Stress <i>RF</i>
Stroke <i>MC</i>	Cancer <i>SEP</i>	High blood pressure <i>MC</i>
Thyroid problem <i>SEP</i>	Cirrhosis <i>MC</i>	HIV <i>SEP</i>
Ulcer <i>SEP</i>	Concussion <i>MC</i>	Hypoglycemia <i>SEP</i>
Congenital defect <i>SEP</i>	Hyperlipidemia <i>RF</i>	Other _____

16. Circle any operations that you have had:

Back <i>SLA</i>	Heart <i>MC</i>	Kidney <i>SLA</i>	Eyes <i>SLA</i>	Joint <i>SLA</i>	Neck <i>SLA</i>
Ears <i>SLA</i>	Hernia <i>SLA</i>	Lung <i>SLA</i>	Other _____		

17. *RF* Circle any who died of heart attack before age 55:

Father Brother Son

18. *RF* Circle any who died of heart attack before age 65:

Mother Sister Daughter

SECTION FOUR - HEALTH-RELATED BEHAVIORS

19. Have you ever smoked? Yes No

20. *RF* Do you now smoke? Yes No

21. *RF* If you are a smoker, indicate the number smoked per day:

Cigarettes: 40 or more 20-39 10-19 1-9

Cigars or pipes only: 5 or more or any inhaled less than 5

22. *RF* Do you exercise regularly? Yes No

23.. Last physical fitness test: _____

24. How many days a week do you accumulate 30 minutes of moderate activity?

0 1 2 3 4 5 6 7 days per week

25. How many days per week do you normally spend at least 20 minutes in vigorous exercise?

0 1 2 3 4 5 6 7 days per week

26. What activities do you engage in a least 1x per week?

27. Weight now: _____ lb. One year ago: _____ Age 21: _____

SECTION FIVE - HEALTH-RELATED ATTITUDES

28. These are traits that have been associated with coronary-prone behavior. Circle the number that corresponds to how you feel towards the following statement:

I am an impatient , time-conscious, hard-driving individual.

Circle the number that best describes how you feel:

6= Strongly agree

5= Moderately agree

4= Slightly agree

3= Slightly disagree

2= Moderately disagree

1= Strongly disagree

29. How often do you experience “negative” stress from each of the following:

	Always	Usually	Frequently	Rarely	Never
Work:	_____	_____	_____	_____	_____
Home or family :	_____	_____	_____	_____	_____
Financial pressure:	_____	_____	_____	_____	_____
Social pressure:	_____	_____	_____	_____	_____
Personal health	_____	_____	_____	_____	_____

30. List everything not included on this questionnaire that may cause you problems in a fitness test or fitness program:

Action Codes

EI = Emergency Information- must be readily available

MC= Medical Clearance needed-do not allow exercise without physician’s permission.

SEP= Special Emergency Procedures needed- do not let participant exercise alone; make sure the person’s exercise partner knows what to do in case of an emergency

RF= Risk Factor of CHD (educational materials and workshops needed).

SLA= Special or Limited Activities may be needed- you may need to include or exclude specific exercises.

Other (not marked) = Personal information that may be helpful for files or research.