Health History Questionnaire for Wellness/Fitness Program

All of your responses are completely confidential. Group summaries or activity reports have individual identifiers removed. All information collected is subject to the Privacy Act of 1974. **If you require special assistance with the questionnaire or with arranging fitness appointments or services, please call _____ for further assistance.**

ALL INFORMATION MUST BE COMPLETED!

Name: _____ **Gender:** _____

Age _____ **Birth Date:** ____ / 01 / ____ *(record only month/year)*

Office Address: _____ **Room #:** _____

Office Phone: _____ **Ext:** _____

E-mail address: _____

Federal Agency: _____ **Division:** _____

Personal Physician: _____ **Phone:** _____

Address: _____ **Fax:** _____

City: _____ **State:** _____ **Zip:** _____

Emergency Contact: _____ **Phone:** _____

MANDATORY FIELD
For completion by FOH Staff

	INITIAL	ANNUAL	PERIODIC
Cholesterol (≥200)			_____
HDL (<40)			_____
LDL (≥ 130)			_____
Glucose (≥100)			_____
Blood Pressure			_____
Height (in.)			_____
Weight			_____
BMI (kg/m^2)			_____
Waist girth (cm.)			_____
Risk Stratification			**L M H**
Medical Clearance			**Y N**
Next Restrat			_____ / _____ Mo. Yr.

1. Have you ever had any of the following? (Please check all that apply) ..... ☐ Yes ☐ No

- ☐ Heart attack, failure or surgery
- ☐ Pacemaker or defibrillator
- ☐ Diabetes
- ☐ Catheterization or angioplasty
- ☐ Heart murmur or valve disease
- ☐ Thyroid disorder
- ☐ Congenital heart disease
- ☐ Asthma, COPD, lung disease
- ☐ Kidney or liver disease

2. Do you have any of the following? (Please check all that apply) ..... ☐ Yes ☐ No

- ☐ Cancer
- ☐ Back pain
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Musculoskeletal problems
- ☐ Blood clots
- ☐ Concerns about the safety of exercise
- ☐ Recent surgery
- ☐ Current pregnancy (due date _____)

3. Has a doctor ever told you that you should not exercise? ☐ Yes ☐ No

4. If you answered yes to any of Questions 1 to 3, please describe _____

_____

_____

_____

_____

5. Have you experienced any of the following within the past 12 months***:

a. Pain or discomfort in the chest, neck, jaw, or arms at rest or during physical activity ..... ☐ Yes ☐ No
b. Shortness of breath or wheezing at rest or with mild exertion ..... ☐ Yes ☐ No
c. Dizziness, fainting or blackouts. ..... ☐ 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 than one occasion) ..... ☐ Yes ☐ No
g. Burning or cramping in the legs when you walk short distances ..... ☐ Yes ☐ No
h. Unusual fatigue or shortness of breath with usual activities ..... ☐ Yes ☐ No

*** If yes, please describe: _____

*** Have you discussed any of the above with your personal physician? ..... ☐ Yes ☐ No

6. Are you a male over 45 years of age? …….. ☐ Yes ☐No

7. Are you a female over 55 years of age, have had a hysterectomy or are post menopausal? ..... ☐ Yes ☐ No

8. Have either your father or brother prior to age 55 and/or mother or sister prior to age 65 had heart disease, a heart attack, or stroke? ..... ☐ Yes ☐ No

9. Do you currently smoke cigarettes or have you quit within the last 6 months or have you been exposed to environmental tobacco smoke?..... ☐ Yes ☐ No

10. Do you engage in moderate physical activity for at least 30 minutes a day on three days a week? ... ☐ Yes ☐ No

11. Has your doctor ever told you that you need to lose weight? ..... ☐ Yes ☐ No

12. Has your doctor ever told you that you have high blood pressure or are you on medicine to control your blood pressure? ..... ☐ Yes ☐ No

13. Has your blood glucose level ever been high or has a doctor ever told you that you have prediabetes?

14. Has your doctor ever told you that your cholesterol is high? ..... ☐ Yes ☐ No

15. Please list all prescription and over-the-counter medications you have been prescribed.

Medicine:	Reason for taking:	Dosage:	Amount/Frequency:

16. Are there any medicines that your physician has prescribed to you in the past 12 months which you are currently not taking? (please note above under frequency) ..... ☐ Yes ☐ No

17. Are you currently being treated for any other medical conditions?..... ☐ Yes ☐ No

If yes please list them here _____

I have answered these questions accurately and completely. I understand that my medical history is a very important factor in the development of my fitness/wellness program. Medical or physical conditions which are known to me, but which I do not disclose to the staff may result in serious injury to me. If any of the above conditions change, I will immediately inform the FOH Fitness Professional. I knowingly and willingly assume all risks of injury resulting from my failure to disclose accurate, complete and updated information in accordance with the above questionnaire.

Employee Signature: _____ **Date:** _____

FOH Staff Signature: _____ **Date:** _____

☐ **Cleared for exercise testing/exercise program**
☐ **Medical Clearance Required or Assumption of Risk Form Completed**