Health History Form

Instructions: Fill in the following information about yourself.

Name _____ Resting Heart Rate _____

Age _____ Blood Pressure (if known) _____

Date _____ Total Cholesterol (if known) _____

Total/HDL (if known) _____

Has a physician ever told you or do you have any reason to believe that you have or ever have had any of the following:

Yes	Current (C) / Past (P)	
		1. Hypertension (high blood pressure)
		2. Diseases of the arteries or heart
		3. Stroke
		4. Abnormal ECG (electrocardiogram), racing heart rate, or heart murmur
		5. Abnormal chest X ray
		6. Recurrent symptoms such as chest pain or dizziness
		7. Breathing problems such as shortness of breath or nighttime breathing problems
		8. Ankle swelling or lower leg pain
		9. Smoking. If currently, how much?
		If you smoked in the past, how many years ago did you quit?
		10. Diabetes or abnormal blood sugar test
		11. Close relatives (mother, father, sibling) who have a history of heart disease.
		If yes, how many had the disease prior to age 55?
		12. Exercise regularly and vigorously less than 3 days a week.
		13. Orthopaedic or muscular problems. If so, please list.
		14. Asthma
		15. Other lung disease
		16. Epilepsy
		17. Anemia
		18. Overweight –
		19. Take prescription drugs. If yes, please list the drugs and the reason for their use
		20. Any other major health problems. If so, please list.
