



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!

MANDATORY FIELD

For completion by FOH Staff

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: _____

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

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