

Health History Questionnaire

Name _____

Home Address _____

Phone _____

Height _____ Weight _____

Gender _____ Birth date _____ Age _____

Regular physical activity is safe for most people. However, individuals should check with their doctor before they start an exercise program. To consult with your doctor before starting to exercise with the Rambling River Center, please read the following questions carefully and answer each one honestly. All information will be kept confidential and will be shared only with employees who work with you on your exercise program or supervise the program, or health care personnel who may need to provide treatment to you

Please check YES and NO

Yes or No

- ___ ___ 1. Do you have a heart condition?
- ___ ___ 2. Have you ever experience a stroke?
- ___ ___ 3. Do you have epilepsy?
- ___ ___ 4. Do you have diabetes?
- ___ ___ 5. Do you have emphysema?
- ___ ___ 6. Do you feel pain in your chest when you engage in physical activity?
- ___ ___ 7. Do you have chronic bronchitis?
- ___ ___ 8. In the past month, have you had chest pain when you were not doing physical activity?
- ___ ___ 9. Do you ever lose consciousness or control of your balance due to chronic dizziness?
- ___ ___ 10. Are you currently being treated for a bone or joint problem that restricts you from engaging in physical activity?
- ___ ___ 11. Do you have high blood pressure?
- ___ ___ 12. Has anyone in your immediate family had a heart attack, stroke, or cardiovascular disease before age 55?
- ___ ___ 13. Do you have high cholesterol?
- ___ ___ 14. Do you smoke?
- ___ ___ 15. Are you a male over 44 years of age?
- ___ ___ 16. Are you a female over 54 year of age?
- ___ ___ 17. Are you currently exercising LESS than 1 hour per week?
If you answered no, please list you activities:

- ___ ___ 18. Are you currently taking any medication?
Please list the medication and it's purpose:

What are your specific fitness goals toward fitness? (check all that may apply)

- | | |
|--|--|
| <input type="checkbox"/> Increase strength and endurance | <input type="checkbox"/> Improve flexibility |
| <input type="checkbox"/> Improve cardiovascular fitness | <input type="checkbox"/> Improve muscle tone |
| <input type="checkbox"/> Reduce body fat | <input type="checkbox"/> Improve muscle mass |
| <input type="checkbox"/> Exercise regularly | <input type="checkbox"/> Injury rehabilitation |
| <input type="checkbox"/> Other _____ | |

What are your specific heal goals? (check all that may apply)

- | | |
|---|---|
| <input type="checkbox"/> Reduce Stress | <input type="checkbox"/> Improve nutritional habits |
| <input type="checkbox"/> Control blood pressure | <input type="checkbox"/> Control cholesterol |
| <input type="checkbox"/> Stop smoking | <input type="checkbox"/> Achieve balance in life |
| <input type="checkbox"/> Improve productivity | <input type="checkbox"/> Reduce back pain |
| <input type="checkbox"/> Feel better overall | <input type="checkbox"/> Increase my health awareness |
| <input type="checkbox"/> Other (please be specific) _____ | |

I have read, understood and completed this questionnaire. Any questions that I had were answered to my satisfaction.

Name _____ Date _____

Signature _____

Staff Use Only

Cleared to exercise _____ Not cleared to exercise _____

Reason _____

Staff Signature _____

Resting heart rate _____

Resting blood pressure _____