MEDICAL HEALTH HISTORY

New member: ☐YES ☐ NO

All information you provide is personal and confidential. The information will enable us to better understand you and your health and fitness habits as well as inform you of any potential risks. Please consult your physician before beginning any type of exercise program.

NAME _____ ID_____ DATE _____/_____/_____
Address _____
City, State Zip _____
Employer _____
Phone (H)_____(W)_____Email_____
Date of Birth _____/_____/_____ Male _____ Female _____
Emergency Contact_____ Phone _____ Relation _____
Physician's Name _____ Phone _____ Fax _____

GENERAL

Height _____ ft. Weight _____lbs.

Any unexplained significant weight loss/gain . . . Within the last 6 months ☐ Within the last year ☐ NO ☐
If yes, please explain:

What was your most recent blood pressure reading? _____/_____ mm Hg Date_____

Do you currently exercise? YES ☐ NO ☐
If yes, how long have you been exercising regularly? _____
What exercise do you do and how often?

MEDICAL DIAGNOSES

Have you ever had any of the following?

Heart attack	YES ☐	NO ☐	**Emboli –** (Blood clot)	YES ☐	NO ☐
Angina	YES ☐	NO ☐	**Coronary Artery Disease**	YES ☐	NO ☐
Asthma	YES ☐	NO ☐	**Stroke**	YES ☐	NO ☐
Anemia	YES ☐	NO ☐	**Cancer**	YES ☐	NO ☐
Osteoporosis	YES ☐	NO ☐	**Pulmonary Disease**	YES ☐	NO ☐
Cardiovascular surgery	YES ☐	NO ☐	**Heart Valve Problems**	YES ☐	NO ☐
Currently pregnant	YES ☐	NO ☐	**Rheumatic Fever**	YES ☐	NO ☐
Emphysema	YES ☐	NO ☐	**Phlebitis -**	YES ☐	NO ☐
Allergies	YES ☐	NO ☐	(inflammation of a vein)		

Please list all known allergies:

Any special conditions not listed above:

If you answered, "YES" to any of the above Medical Diagnoses,
It is <u>RECOMMENDED</u> that you consult with your physician before beginning your exercise program.

MEDICATIONS

Please list any medications you are currently taking including but not limited to prescriptions, allergy medications, ergogenic aids, diet supplements, vitamins, minerals, etc.

Medication	Reason	Dosage

-over-

MAJOR RISK FACTORS

1. Are you a man over the age of 45 or a woman over the age of 55, Having had a hysterectomy, or are postmenopausal? YES ☐ NO ☐
2. Has your father or brother experienced a heart attack before age 55? Or has your mother or sister experienced a heart attack before the age of 65? Who? _____ YES ☐ NO ☐
3. Has your doctor ever told you that you might have high blood pressure? YES ☐ NO ☐
4. Do you have cholesterol above 200 ml/dl? Total cholesterol _____ HDL _____ Date tested _____ Unknown _____ YES ☐ NO ☐
5. Do you have impaired fasting glucose (diabetes)? If yes – Do you take insulin? YES ☐ NO ☐ What year were you diagnosed? _____ YES ☐ NO ☐
6. Are you physically inactive (i.e., you get less than 30 minutes of physical activity on at least 3 days per week YES ☐ NO ☐
7. Do you currently smoke or have you quit smoking in the last 6 months? I smoke (#)_____cigarettes per day/week (circle one) for _____years. I smoked (#)_____cigarettes per day/week (circle one) _____years ago. YES ☐ NO ☐
8. Are you > 20 pounds overweight? YES ☐ NO ☐

If you are a man over the age of 45 or a woman over the age of 55
OR if you answered "YES" to two (2) or more of the above Major Risk Factors,
It is <u>RECOMMENDED</u> that you receive physician's clearance before beginning your exercise program.

MAJOR SIGNS/SYMPTOMS SUGGESTIVE OF CARDIOVASCULAR AND PULMONARY DISEASE

1. Pain discomfort (or anginal equivalent) in the chest, neck, jaw, arms, or other areas that may be due to ischemia (decreased blood flow) YES ☐ NO ☐
2. Shortness of breath at rest or w/mild exertion YES ☐ NO ☐
3. Dizziness or syncope at rest or w/mild exertion YES ☐ NO ☐
4. Orthopnea/paroxysmal nocturnal dyspnea (labored breathing) at rest or w/mild exertion YES ☐ NO ☐
5. Edema (excessive accumulation of tissue fluid) YES ☐ NO ☐
6. Palpitations or tachycardia (sudden rapid heart beat) YES ☐ NO ☐
7. Intermittent Claudication (lameness due to decreased blood flow) YES ☐ NO ☐
8. Known heart murmur (abnormal heart sound) YES ☐ NO ☐
9. Unusual fatigue or shortness of breath with usual activities YES ☐ NO ☐

If you answered, "YES" to any of the above Major Signs and Symptoms listed above
Or have known cardiovascular, pulmonary, or metabolic disease (see below for descriptions),
It is <u>STRONGLY RECOMMENDED</u> that you seek physician's clearance before beginning your exercise program.

Cardiovascular – cardiac, peripheral vascular, cerebro-vascular disease
Pulmonary – Chronic obstructive pulmonary disease, asthma, interstitial lung disease, or cystic fibrosis
Metabolic Disease – Diabetes mellitus (types 1 and 2), thyroid disorders, renal or liver disease.

I understand this Health History Questionnaire has been provided to me for the purpose of helping me better understand any potential risks associated with a workout program. I also understand I should share this information with my physician and seek his or her approval prior to beginning an exercise program. I understand the information I have provided will be maintained in my membership file for use in case of a medical emergency. My signature signifies that all of the above is true, to the best of my knowledge. Any information left unanswered was done so intentionally. If any of the above information changes, I agree to submit these changes in writing to this facility's wellness professional for an update to my membership file.

Signature: _____ Date: _____Received by:_____ Date:_____

I understand this Health History Questionnaire has been provided to me for the purpose of helping me better understand any potential risks associated with a workout program, to share with my physician in order to obtain his or her approval before beginning an exercise program, and to be maintained as part of my membership file in case of a medical emergency**. I do not want to complete this questionnaire and understand I assume full responsibility for any risks associated with my participation in an exercise program.**

Signature: _____ Date: _____Received by:_____ Date:_____

Wellness Representative Signature: _____ Date: _____ Notes Attached: _____

Note: All Major Risk Factors, Signs and Symptoms classifications are taken directly from Whaley, Mitchell H, ed. *ACSM's Guidelines for Exercise Testing and Prescription.* Philadelphia, PA: Lippincott Williams & Wilkins, 2006.