

NCH Wellness Center Health History Questionnaire

First Name _____ Last Name _____

Emergency Contact Name _____ Emergency Contact Phone _____

Have you ever had any of the following?

Heart Attack	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Emboli (blood clot)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Angina	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Coronary Artery Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Asthma	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Stroke	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Anemia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Cancer	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Osteoporosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Pulmonary Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Heart Surgery	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Heart Valve Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Currently Pregnant	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Rheumatic Fever	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Emphysema	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Phlebitis (vein inflammation)	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Please list all known allergies: _____

Please list any conditions not noted above: _____

If you answered "yes" to any of the above Medical Diagnoses, it is STRONGLY RECOMMENDED that you consult your physician before beginning your exercise program.

Are you a male over the age of 45 or a female over the age of 55, had a hysterectomy or are postmenopausal?
 YES NO

Has your father or brother experienced a heart attack before the age of 55 or has your mother or sister experienced a heart attack before the age of 65? Who _____
 YES NO

Has your doctor ever told you that you might have high blood pressure?
 YES NO

Do you have cholesterol above 200ml/dl?
 YES NO

Do you have impaired fasting glucose (diabetes)?
 YES NO

Are you physically inactive? (i.e., you get less than 30 min of physical activity on at least 3 days per week.)
 YES NO

Do you currently smoke or have you quit smoking within the last 6 months?
 YES NO

Are you more than 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 STRONGLY RECOMMENDED that you receive physician's clearance before beginning your exercise program.

Do you have any of the following?

- | | | |
|---|------------------------------|-----------------------------|
| Pain/discomfort (or angina equivalent) in the chest/neck/jaw/arms/other areas | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Shortness of breath at rest or with mild exertion | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Dizziness or syncope with rest or mild exertion | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Labored breathing at rest or with mild exertion | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Edema (excessive accumulation of tissue fluid) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Palpitations or tachycardia (sudden rapid heart beat) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Intermittent claudication (lameness due to decreased blood flow) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Known heart murmur (abnormal heart sound) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Unusual fatigue or shortness of breath with usual activities | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

If you answered "YES" to any of the Signs & Symptoms listed above OR have known cardiovascular, pulmonary, or metabolic disease (see descriptions below), it is STRONGLY RECOMMENDED that you receive physician's clearance before beginning your exercise program.

Cardiovascular: cardiac, peripheral vascular, cerebro-vascular disease

Pulmonary: chronic obstructive pulmonary disease, asthma, interstitial lung disease, cystic fibrosis

Metabolic Disease: Diabetes Mellitus (Type I & II), 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 an exercise program. I also understand that 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: _____

Wellness Representative Signature: _____

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 that I assume full responsibility for any risks associated with my participation in an exercise program.**

Signature: _____

Date: _____

Wellness Representative Signature: _____

Date: _____

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.