

HEALTH SCREENING QUESTIONNAIRE

Date: _____

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Name: _____ Sex: M F DOB: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Emergency Contact:

Name: _____ Phone: _____

Relationship: _____

Name of your physician: _____ Phone: _____

Please answer the following questions as honestly as you can. Your patterns of responses will determine your eligibility to participate in each of the services offered.

Date of your last physician checkup: _____

.....
Known Diseases (Medical Conditions)

1. List the medications you take on a regular basis. (Include aspirin, vitamins & minerals, prescription and non-prescription)

2. Do you have diabetes? No Yes
a. If yes, please indicate if it is insulin dependent diabetes mellitus
(IDDM) or non-insulin dependent diabetes mellitus (NIDDM). IDDM NIDDM

3. Have you had a stroke?. No Yes

4. Have you ever had a heart attack or heart trouble?. No Yes

5. Do you take asthma medication?. No Yes

6. Are you, or do you have reason to believe you may be, pregnant? No Yes

7. Is there any other physical reason that prevents you from participating
in an exercise program (e.g. cancer, osteoporosis, severe arthritis,
mental illness, thyroid, kidney or liver disease)?. No Yes

(OVER)

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Signs and Symptoms of Disease

8. Do you often have pains in your heart, chest, neck, jaw, arms or other areas, especially during exercise? No Yes
9. Do you often feel faint or have spells of severe dizziness during exercise?. No Yes
10. Do you experience unusual fatigue or shortness of breath at rest or with mild exertion? No Yes
11. Have you had an attack of shortness of breath that came on after you stopped exercising? No Yes
12. Have you been awakened at night by an attack of shortness of breath?. No Yes
13. Do you experience swelling or accumulation of fluid in or around your ankles?. . . No Yes
14. Do you often get the feeling that your heart is beating faster, racing, or skipping beats, either at rest or during exercise? No Yes
15. Do you regularly get pains in you calves or lower legs during exercise which are not due to soreness or stiffness? No Yes
16. Has your doctor ever told you that you have a heart murmur?. No Yes

Cardiac Risk Factors

17. Do you, or did you ever, smoke cigarettes on a daily basis? No Yes
 a. If you did smoke when did you quit? (mm/dd/yy) _____
18. Has your doctor ever told you that you have high blood pressure?. No Yes
19. Has a first degree relative (e.g. father, mother, sister, brother, or child) suffered from a heart attack or been diagnosed with cardiovascular disease?. No Yes

| Relative | Age | Did they pass away? |
|----------|-----|---------------------|
| | | |
| | | |
| | | |

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Current Physical Activity Patterns and Future Intentions

1. Does your job involve sitting for a large part of the day? No Yes

2. What are your current physical activity patterns?

a) Frequency: _____ activity sessions per week

b) Intensity: Sedentary Moderate Vigorous

c) Duration: _____ minutes per session (on the average)

d) How long have you been following this routine? (circle one)

Less than 3 months 3-6 months 6-12 months More than a year

3. What types of exercises do you regularly do? Please check all that apply.

- | | | |
|--|---|--|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Running | <input type="checkbox"/> Stair-stepping |
| <input type="checkbox"/> Brisk Walking | <input type="checkbox"/> Elliptical machine | <input type="checkbox"/> Weight-lifting |
| <input type="checkbox"/> Swimming | <input type="checkbox"/> Cycling | <input type="checkbox"/> Pilates |
| <input type="checkbox"/> Yoga | <input type="checkbox"/> Racquet sports | <input type="checkbox"/> Basketball/Volleyball |
| <input type="checkbox"/> Other: | | |

4. Are you interested in changing your activity routine? If so, please explain.

5. What are your fitness goals?

6. How committed are you to improving your fitness at this time?

Evaluating Clinician's Comments:

CLINICIAN SIGNATURE: _____

DATE: _____