Health Status Questionnaire

This Information is strictly confidential. Your knowledge and consent will be required for release of this medical record. Please fill out this page completely and to the best of your knowledge. Do not skip any lines. Please check the appropriate "yes" or "no" box and fully explain any "yes" answers. Please provide emergency contact information.

Personal Information

First Name_____Last_____MI___
Mailing Address_____
Home Phone_____ Business phone_____
DOB_____ Email_____

Emergency Contact: _____Relationship_____
Home phone_____ Business phone_____

Personal physician _____Phone_____
Address_____

Last Medical physical exam_____
Last physical fitness test _____

1. Sex (circle one): Female Male

2. Numbers of hours worked per week: Less than 20 20-40 41-60 over 60

3. More than 25% of time spent on job (circle all that apply)
Lifting or carrying loads Standing Walking Driving Sitting at a desk

Medical History

4. Circle any who have died of heart attack before age 55
Father Brother Son

5. Circle any who have died of heart attack before age 65
Mother Sister Daughter

6. Circle operations you have had:
Back Heart Kidney Eyes Joint Neck Ears Hernia Lung Other

Personal History: Have you ever or do you currently have:

	YES	NO		YES	NO
Alcoholism			Heart problem		
Allergies			High/Low Blood Pressure		
Anemia, Sickle Cell			High Cholesterol		
Asthma			Hyperlipidemia		

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Arthritis			Infectious Mononucleosis		
Back strain			Migraine Headaches		
Bleeding trait			Mental illness		
Bronchitis, Chronic			Neck Strain		
Cancer			Obesity		
Chest pain/ Heart Attack			Phlebitis		
Cirrhosis			Rheumatoid Arthritis		
Concussion			Stroke		
Congenital defect			Thyroid Problem		
Diabetes			Ulcer		
Emphysema			Skin Problems		
Fainting/Dizziness			Epilepsy		
Gout					
Hearing Aids					

Injuries to the following areas

Concussion/Skull			Back/Spine		
Hip/Pelvis			Hip/Pelvis		
Shoulder/Arm			Elbow/Forearm		
Knee/Thigh			Ankle/Lower leg/Foot		
Wrist/Hand			Rib/Chest		

How will any of the above conditions affect your ability to perform?

_____

_____

What special accommodations will you need to help you successfully complete this course?

_____

_____

Anything else not listed? If yes please explain.

_____

_____

7. Do you now smoke (or have smoked in last 6 months)? Yes No

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8. If you are a smoker, indicate number smoked per day:
Cigarettes: 40 or more 20-39 10-19 1-9
Cigars or pipes only: 5 or more or any inhaled Less than 5, none inhaled

Are you currently taking any of the following medication: Please circle all that apply.

Blood thinner	Diabetics	Digitalis
Diuretic	Epilepsy medication	Heart rhythm medication
High blood pressure medication	Insulin	Nitroglycerin
Other		

9. Do you exercise regularly (i.e., accumulate at least 30 min per day, at least five days/week? Yes No

10. How many days per week do you accumulate 30 minutes of moderate activity?

0 1 2 3 4 5 6 7 days per week

11. How many days per week do you normally spend at least day minutes in vigorous exercise?

0 1 2 3 4 5 6 7 days per week

12. Can you walk 4 miles briskly without fatigue? Yes No

13. Can you jog 3 miles continuously at a moderate pace without discomfort? Yes No

14. Weight now: _____lb. One year ago: _____lb. Age 21:_____lb.

15. List everything not already included on this questionnaire that might cause you problems

in a fitness test or fitness program:

_____
_____
_____
_____
_____
_____

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