

Health History Questionnaire

Name _____ Age _____ M / F

Address _____

Telephone _____ (home) _____ (work)

Personal Physician _____ Location _____

Emergency contact _____ Phone _____

PLEASE CIRCLE YES OR NO TO THE FOLLOWING:

History

Have you had or now have:

Heart attack	Y	N
Heart surgery	Y	N
Congenital Heart Disease	Y	N
Heart rhythm disturbance	Y	N
Lung disease	Y	N
Asthma	Y	N
Kidney disease	Y	N
Diabetes	Y	N
Heart murmur	Y	N
Arthritis	Y	N

Symptoms

You experience chest discomfort with exertion	Y	N
You experience unreasonable breathlessness	Y	N
You experience dizziness, fainting or blackouts	Y	N
You take heart medication	Y	N

Other Health Issues

Cramping sensation in lower legs when walking short distances	Y	N
Musculoskeletal problems that limit physical activity	Y	N
Have concerns about the safety of exercise for you	Y	N
Take prescription medications	Y	N
You are pregnant	Y	N

If you marked YES to any of these statements in this section, consult your physician or other appropriate health care provider before engaging in exercise. You may need to use a facility with a medically qualified staff.

Cardiovascular Risk Factors

You are a man older than 45 years	Y	N
You are a woman older than 55 years	Y	N

