INDIVIDUAL FITNESS & MEDICAL HISTORY QUESTIONNAIRE

Many health benefits are associated with regular exercise and participation in an Individual Fitness Program. This is a sensible first step to take if you are planning to increase the amount of physical activity in your life. This information is used solely as an aid to health care and will not be released without your consent.

SECTION A: DEMOGRAPHICS

Name ____ Date of Birth: _________________

Phone #: (   )____________________ E-mail Address: ____

Address ____ City __________________ State _____ ZIP ________

Physician's name: ____________________________________ Physician's Phone: _________________________

Emergency Contact Name: ______________________________ Emergency Contact Phone # __________________

SECTION B: RISK FACTORS

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For most people physical activity should not pose any problem or hazard. This form has been designed to identify the small number of individuals for whom physical activity might be inappropriate or those who should have medical advice concerning the type of activity most suitable for them.

YES	NO	
_________		1. Have you ever had or has your doctor ever diagnosed you as having heart trouble or coronary disease?
____	____	2. Has any immediate family member had heart problems or sudden death before the age of 55, if you are male, or age 65, if you are female?
____	____	3. Do you have a history of high blood pressure (above 140/90) or are you on medication?
____	____	4. Do you have diabetes?
____	____	5. Do you smoke cigarettes?
____	____	6. Has your doctor ever said you have high cholesterol? (Serum Cholesterol, if known = _____)
____	____	7. Are you overweight? (Height = _____ and Weight = _____)
____	____	8. Is your diet heavy in fatty foods and red meat?
____	____	9. Are you a female over age 55 or male over age 45?
____	____	10. Are you sedentary?

SECTION C: HEALTH HISTORY

Common sense is your best guide in answering these few questions. Please read them carefully and check the correct answer opposite the question if it applies to you.

1. Are you presently involved in a regular exercise program? . ____ Yes ____ No
2. How active do you consider yourself? ___ Sedentary ____Lightly active ____Moderately active ____ Highly active
3. Do you now or have you ever smoked? . ____ Yes ____ No
   (a) If you previously smoked, how many years? ___ packs per day? ___ date you quit?___________
(b) If you currently smoke, for how many years? ___ packs per day? ___
4. How would you characterize your life? . ____ Highly stressful ____ Moderately stressful ____Low in stress
5. Are you now or have you ever been on "a diet"? .____ Yes . ____ No
If yes, please explain.
6. Would you consider your body to be: . ____overweight ____. average . ____underweight

7. How many meals do you usually eat per day? _________ Do you usually eat breakfast? ____. Yes . ____ No
8. My diet is: .____ Unrestricted . ____Low fat/low cholesterol . ____ Strict vegetarian
.____ Ovo-lacto-vegetarian (eat eggs/milk) . ____ Avoid red meat, but eat chicken/fish
. Other? (low sodium, etc.) ____
9 How would you describe your nutrition habits? . ____ Good . ____ Fair . ____ Poor
10. Please describe your knowledge of nutrition. . ____ Good ____ Fair . ____ Poor

CURRENT EXERCISE PROGRAM (IF ANY):

EXERCISE TYPE	FREQUENCY (# of days/week)	DURATION (Time spent in activity)	EXERCISE (comment)
Cardiovascular			
Weights/strength			
Stretching/flexibility			

New Exercise Program Goals:

- ____
- ____
- ____

Days available per week? 1 2 3 4 5 6 7 **Which days? Varied M T W TH F SA SU**

Time available per day (minutes)? 20 or less 30 45 60 over 1 hour

SECTION D: MEDICAL HISTORY

It is always a good idea, if you have not recently done so, to consult with your personal physician before starting or increasing your physical activity.

Present & Past History

Check any conditions or diseases you now have or have had in the past.

_____ Peripheral vascular disease (Claudication - calf pain with exercise)
_____ Chest discomfort
_____ Extra, skipped, or rapid heartbeats or palpitations
_____ Heart murmurs
_____ Ankle swelling, varicose veins or blood clots in the legs (phlebitis)
_____ Unusual shortness of breath with mild exertion
_____ Light-headedness, dizziness or fainting

*Please note, the conditions listed above could be **symptoms** of cardio-pulmonary / metabolic disease*

_____ Heart attack or heart surgery
______ Low blood pressure
______ Epilepsy or seizures
______ Emphysema
______ Fatigue/lack of energy
______ Foot problems
______ Back problems
______ Neck problems
______ Arthritis or Bursitis

_______ Stroke
______ Cold hands or feet
______ Asthma
______ Bronchitis
______ Swollen/stiff joints
______ Knee problems
______ Shoulder problems
______ Broken bones

If you checked any of the conditions above, please explain:____

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