Health History Questionnaire

Northern Michigan University - Exercise Science Laboratory Services

Name______________________________  Today’s Date ____________________

Gender __________________ Date of Birth (Month/Day/Year)________________________ Age______

Home Address_________________________________________________________ Phone ____________________

Business Address_________________________________________________________ Phone ____________________

Email ___________________________ Best Time to Contact You - Home ___________ Work ________________

Please answer the following questions as accurately as possible. All information will be kept confidential.

Past History
Check those questions to which your answer is “yes”. Leave others blank.

Have you ever had:

- Heart attack How many years ago? ________ Thyroid problems
- Rheumatic Fever
- Heart murmur
- Disease of the arteries
- Varicose veins
- Arthritis—list affected joints: ____________________________
- Diabetes or abnormal blood sugar test
- Phlebitis
- Injuries to back, arms, legs, joints
- Dizziness or fainting spells

Are you currently experiencing any of these problems? ______ yes ______ no
If yes, explain:

Have you ever had a stress test or exercise ECG? ______ yes ______ no
If yes, please explain when and for what reason:

Present History
Check those questions to which your answer is “yes.” Leave others blank.

- Has a doctor ever said that your blood pressure was too high or low?
- Do you ever have pain in your heart or chest?
- Are you often bothered by a thumping of the heart?
- Does your heart often race like mad?
- Do you ever notice extra heart beats or skipped beats?
- Are your ankles often badly swollen?
- Do cold hands or feet trouble you even in hot weather?
- Has a doctor ever said that you had or have heart trouble, an abnormal electrocardiogram (ECG or EKG), heart attack, or coronary?
- Do you suffer from frequent cramps in your legs?
- Do you get out of breath long before anyone else?
- Do you sometimes get out of breath when sitting still or sleeping?
- Has a doctor ever told you your cholesterol level was high?
- Do you have any significant vision or hearing problems?
- Are you currently pregnant? If so, please list expected date of delivery.

Please explain further any questions to which you answered “YES”:

~over~
Family History
Briefly describe your family medical history, particularly in regard to cardiovascular disease. (heart attacks, strokes, etc.)

Medications
Please list any medications which you are currently taking and indicate the conditions for which you are taking them. Include both prescription and non-prescription drugs, dosages, number of times per day taken, and time of day usually taken.

Smoking
Have you ever smoked cigarettes, cigars or a pipe? ______ Yes ______ No

If NO, skip to DIET section.

Do you smoke presently? ______ Yes ______ No  How many packs per day?

If you have quit smoking, when was it?

Do you use chewing tobacco? ______ Yes ______ No

Diet
Present Weight _________ Height__________ What do you consider a good weight for yourself? ______ lbs.

What is the most you have ever weighed (including when pregnant)? _______________ lbs.

At what age? _______________ years

Are you currently following any type of weight-reducing diet? ______ Yes ______ No

If yes, describe or name the diet:

If you’ve lost weight using this diet, how much over what amount of time?

Exercise
Have you exercised regularly during the past 12 months? ______ Yes ______ No

If yes, answer the following:

Type of Exercise  Days/Week  Minutes/Day

__________________________________________________________________________________________________

Occupation:  ______________________________________________________________________________________

Name and address of your physician(s):  __________________________________________________________________

__________________________________________________________________________________________________

☐ Please initial in box if you want a copy of the Physical Fitness Assessment results sent to your physician(s) listed above.