Northern Michigan University - Exercise Science Laboratory Services

Health History Questionnaire

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? _____
_____ 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

_____ Thyroid problems
_____ Pneumonia
_____ Bronchitis
_____ Asthma
_____ Abnormal chest x-ray
_____ Other lung diseases
_____ Polio
_____ Nervous or emotional disorders
_____ Strokes
_____ Anemia
_____ Epilepsy or seizures

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.