



Health, Medical History, and Physical Activity¹

I. General Information

Name (Print): _____

Address (Print): _____

Number

Street

Apt. #

City

State

Zip Code

Country

Date

Telephone: () _____ E-mail: _____

Name of Nearest Relative (Print): _____

Relation: _____

Address of Nearest Relative (Print): _____

Number

Street

Apt. #

City

State

Zip Code

Country

Telephone: () _____ E-mail: _____

Gender: M F Date of Birth: _____
Month Day Year

Marital Status: Married Divorced Widowed Single

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II. Exercise Risk Stratification Information

1. Do you ever experience any of the following signs or symptoms?

Yes

No

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Pain, discomfort in the chest, neck, jaw, arms, or other areas. |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath at rest or with mild exertion. |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness or fainting. |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty breathing while lying down, or sudden awakening at night with difficulty breathing and/or anxiety. |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling of the ankles (excluding swelling during menses in women). |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart arrhythmia of any kind (e. g., skipped beats). |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart palpitations (unusually strong or rapid beats) or tachycardia (bouts of accelerated heart rate). |
| <input type="checkbox"/> | <input type="checkbox"/> | Intermittent pain in any extremities (claudication). |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur. |
| <input type="checkbox"/> | <input type="checkbox"/> | Unusual fatigue or shortness of breath with usual activities. |

2. a. Has any male first-degree relative (i. e., father, brother, son) experienced a myocardial infarction (heart attack), coronary revascularization (“bypass” surgery) or sudden death before the age of fifty-five (55)?

Yes No

b. Has any female first-degree relative (i. e., mother, sister, daughter) experienced a myocardial infarction (heart attack), coronary revascularization (“bypass” surgery) or sudden death before the age of sixty-five (65)?

Yes No

3. Are you currently a cigarette smoker or have you been a cigarette smoker during the last six months?

Yes No



4. a. What is your blood pressure?

Systolic _____ mg Hg Diastolic _____ mg Hg Don't know _____

Indicate the source of this information _____
and attach supporting documentation such as a record of the pertinent laboratory test.

b. Are you currently taking medicine for hypertension (high blood pressure)?

Yes No

5. a. What is your total serum cholesterol?

High-density lipoprotein (HDL) cholesterol _____ mg/dl
or mmol/L (*indicate which*)

Low-density lipoprotein (LDL) cholesterol _____ mg/dl
or mmol/L (*indicate which*)

Don't know _____

Indicate the source of this information _____
and attach supporting documentation such as a record of the pertinent laboratory test.

b. Are you currently taking any medicine to lower your blood cholesterol?

Yes No

6. What is your fasting blood glucose level?

_____ mg/dl or mmol/l (*indicate which*)

Indicate the source of this information _____
and attach supporting documentation such as a record of the pertinent laboratory test.

7. Body Mass Index

height (inches) _____ x 2.54 = height (cm) _____

waist girth (inches) _____ x 2.54 = waist girth (cm) _____

weight (pounds) _____ x 2.24 = weight (kg) _____

Body mass index (LEAVE BLANK) _____

8. Physical activity levels

a. Do you participate in a regular exercise program?

Yes No



b. Do you accumulate a minimum of 30 minutes per day of moderate exercise at least five days each week?

Yes No

c. How much deliberate physical activity of any kind would you estimate that you currently receive each week?

None (no physical activity) A moderate amount (2 – 3 hrs. per week)
 Very Little (< 1 hrs. per week) Quite a bit (3 – 5 hrs. per week)
 Some (1 – 2 hrs. per week) A lot (more than 5 hrs. per week)

III. Medical History

1. Please list any current medical problems and/or complaints:

2. Have you ever been hospitalized? Yes No

If you have ever been hospitalized, please indicate the reason(s) and approximate dates for each hospitalization (use additional sheets if necessary).

	<u>Reason</u>	<u>Approximate Date(s)</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____



3. Have you ever had surgery? Yes No

If you have ever had surgery, please indicate the reason(s) and approximate dates for each surgery (use additional sheets if necessary).

<u>Reason</u>	<u>Approximate Date(s)</u>
1. _____	_____
2. _____	_____
3. _____	_____

4. Are you currently being treated by a physician for any illness?

Yes No

If you are currently being treated by a physician for any illness, please list below (use additional sheets if necessary).

<u>Illness</u>	<u>Treatment</u>
1. _____	_____
2. _____	_____
3. _____	_____

5. Do you have any allergies?

Yes No

If you have any allergies, please list them in the spaces below (use additional sheets if necessary).

1. _____
2. _____
3. _____



6. Do you have any heart, lung, or metabolic (e. g., diabetes, thyroid) diseases?

Yes No

If you have any such diseases, please list them in the spaces below (use additional sheets if necessary).

- 1. _____
- 2. _____
- 3. _____

7. Are you currently taking any prescription or non-prescription medications?

Yes No

If you are currently taking any medication, please indicate why you are taking it, its generic name and, *if you know it*, its scientific name (use additional sheets if necessary).

<u>Reason for Medicine</u>	<u>Generic name</u>	<u>Scientific Name</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

8. What diseases, if any, run in your family (blood relatives only; use additional sheets if necessary)?

- 1. _____
- 2. _____
- 3. _____



9. Parents

a. Is your mother living? Yes No

Mother's Age _____ Health excellent good fair poor

b. Is your father living?

Father's Age _____ Health excellent good fair poor

10. Yourself

a. Present Occupation _____

b. Years At Occupation _____

c. What Is Your Estimation of Your General Health?

excellent good fair poor

IV. Organ Review

For each of the following organs or organ systems, check all boxes that apply to you and list "other" categories as appropriate. Use additional sheets if necessary.

A. Eyes

nearsighted farsighted astigmatic colorblind

painful eyeballs poor night vision inflamed eyelids

burning bloodshot see double glaucoma

other _____



B. Skin

- rashes poor healing easy bruising acne
- frequent boils dry skin psoriasis eczema
- nail problems itching
- other _____

Describe any treatments or medications you use for skin:

C. Nose and Throat

- sinus trouble postnasal drip hayfever nosebleeds
- loss of smell loss of taste tenderness or sores in nose
- hoarseness difficulty swallowing

D. Mouth

- frequent mouth sores bleeding gums receding gums
- dry mouth burning tongue unusual tooth decay
- other _____

E. Ears

- hearing loss earaches motion sickness
- dizziness loss of balance ringing in ears
- other _____



F. Heart

- palpitations skipped beats flutters pounds
- fainting spells lightheaded when getting up quickly
- chest pain unusual shortness of breath
- other _____

G. Lungs

- cough frequently night sweats asthma bronchitis
- shortness of breath cough up phlegm cough up blood
- other _____

H. Digestive System

- nausea stomach aches gas acidity/heartburn
- ulcers constipation bloating rectal bleeding
- blood in stools diarrhea colitis mucus in stool
- black or tarry stools hemorrhoids rectal spasms
- anal itching other _____
- food intolerances: if you check this box, please complete the following.

- Food intolerance to:** wheat milk/dairy eggs citrus
- fried foods fats yeast
- other _____

- Food cravings for:** chocolate sweets milk
- Cheese bread and related products
- Other _____



I. Genitourinary System

- high frequency of urination
- burning or painful urination
- difficulty starting urination
- difficulty starting urination
- incontinence or dribbling
- other _____
- urgency in urination
- blood in urine
- frequent night urination
- kidney pain/stones
- genital itching or discharge

J. Muscles and Bones

- leg cramps
- muscle weakness
- arthritis (describe) _____
- other _____
- stiffness
- swollen joints
- sore muscles
- painful joints
- low back pain

K. Nervous system

- insomnia
- weakness
- difficulty with gait
- anxiety
- poor concentration
- other _____
- depression
- dropping things
- memory loss
- drowsiness
- anxiety
- panic attacks
- weeping spells
- convulsions
- difficult speech
- frequent nightmares
- irritability
- sweats
- rages



V. For Women Only

1. Do you have regular periods? Yes No

2. Are you currently pregnant? Yes No

3. If you are pregnant, what trimester are you currently in?

First Second Third

4. When is your baby due? _____
Month Day Year

5. Do you plan to become pregnant soon? Yes No

If yes, how soon do you plan to become pregnant?

one month three months six months one year

6. How would you describe your periods?

absent irregular moderate heavy variable

7. How long does your period normally last (in days)? _____

8. Which of the following, if any, do you experience in association with your periods?

cramps bloating moodiness edema (swelling)

other _____ None of these

9. Are you menopausal? Yes No

10. Do you experience hot flashes? Yes No

11. Number of pregnancies you have experienced: _____

12. Number of children you have borne: _____

13. Is there any other pertinent information that might affect your ability to undertake vigorous exercise?

Yes No If yes, explain on reverse side.