Woman's Center for Wellness
exceptional care, centered on you

Health History

The Health History form is designed to help identify individuals for who physical activity might be inappropriate at the present time or recommend an appropriate exercise program. It is not intended to substitute for a complete physical examination and assessment by a physician. It is recommended that each client discuss exercise with a physician prior to initiation of an exercise program. With this understanding, please answer the following questions accordingly.

Last Name _____ First Name _____ Middle Initial _____

Address _____

Email Address _____

Home Phone _____ Work Phone _____ Alternate Phone _____

Gender: Male Female Marital Status: Single Married Divorced Widowed

Spouse's Name _____ Phone _____

Emergency Contact _____ Phone _____

Primary Physician _____ Phone _____

MEDICAL AND LIFESTYLE HISTORY

Instructions

Complete each question accurately. All information provided is confidential. In most cases, please check mark the correct answers. Only check those that apply.

1. Do you have a history of the following conditions, **medically diagnosed** by a physician or a healthcare professional? *Check all that apply.*

☐ Abnormal EKG or Chest x-ray	☐ Bronchitis, Chronic	☐ Cancer	☐ Hip Problems
☐ Cigarette Smoking	☐ Other Lung Disorders	☐ Hearing Loss	☐ Back Problems
☐ High Blood Pressure	☐ Anemia, blood disorder	☐ Vision Loss	☐ Shoulder Problems
☐ High Cholesterol	☐ Liver Disorder	☐ Mental Illness	☐ Neck Problems
☐ Diabetes	☐ Thyroid Disorder	☐ Osteoporosis	☐ Recent Broken Bones
☐ Peripheral Vascular Disease	☐ Kidney Disorders	☐ Osteopenia	☐ Swollen or Painful Joints
☐ Heart Attack or Stroke	☐ Hypoglycemia	☐ Urine Leakage	☐ Major Injury
☐ Irregular Heart Beat or Rhythm	☐ Eating Disorders	☐ Chronic Headaches	☐ Balance Problems
☐ Heart Condition	☐ Gout	☐ Phlebitis or Blood Clot	☐ History of Falling
☐ Heart Murmur	☐ Epilepsy or Seizures	☐ Congenital Defect	☐ Other _____
☐ Stroke	☐ Arthritis	☐ Rheumatic Fever	_____
☐ Emphysema	☐ Fibromyalgia	☐ Foot Problems	_____
☐ Asthma	☐ Hernia	☐ Knee Problems	

Has a doctor given you any activity restrictions? ☐ No ☐ Yes **If Yes, please describe:** _____

_____

2. ☐ Yes ☐ No Do you currently have an illness or infection? _____

3. ☐ Yes ☐ No Have you been hospitalized or had major surgery within the last year?

4. ☐ Yes ☐ No Are you pregnant or have you given birth within the last two months?

5. What operations have you had? Check all that apply and indicate date of operation.

☐ Back _____	☐ Eyes _____	☐ Heart _____	☐ Hysterectomy _____	☐ Lung _____	☐ Other _____
☐ Ears _____	☐ Joint _____	☐ Hernia _____	☐ Kidney ____	☐ Neck _____	_____

6. Have you experienced any of the following symptoms **during exercise or activity** (including walking, climbing, stairs, or working)?

☐ Chest Pain, Heaviness or Tightness ☐ Dizziness or Light-headedness ☐ Please Explain_____
☐ Extreme Breathlessness ☐ Mental Confusion _____
☐ Rapid Heartbeats or Palpitations ☐ Low Back or Neck Pain _____
☐ Shoulder or Arm Pain/Numbness ☐ Leg Pain or Cramping (claudication)

7. Please select any medication or supplements you are currently using:

☐ Diuretics ☐ Nitroglycerin ☐ Herbs or Supplements
☐ Beta Blockers ☐ Cholesterol ☐ NSAIDS/Anti-inflammatory (Motrin®/Advil®)
☐ Vasodilators ☐ Calcium Channel Blockers
☐ Alpha Blockers ☐ Diabetes/Insulin ☐ Pain Medication
☐ Other Cardiovascular Drugs ☐ Chemotherapy/Radiation ☐ Other Drugs_____
☐ Blood Thinners, Aspirin ☐ Antidepressants _____

8. Please list the specific medication names that you are currently taking:_____

_____

_____

9. On average, how many times are you physically active per week?_____

10. How long has it been since you last exercised regularly (2 – 3x per week)?_____

11. On average, how long do you exercise per session?_____

12. On a scale from 1 to 10, how intensely do you exercise?_____

Very Easily 1 2 3 4 5 6 7 8 9 10 *Very Intensely*

13. Which of the following activities do you like to do?

☐ Running / Jogging ☐ Strength Training ☐ Yoga / Martial Arts ☐ Rollerblading or Skating
☐ Walking ☐ Aerobic Classes ☐ Golfing ☐ Other_____
☐ Stair Climbing / Eliptical ☐ Swimming ☐ Gardening / Yard Work
☐ Bicycle / Spinning ☐ Dancing ☐ Bowling

14. ☐ Yes ☐ No Do you currently smoke? How long have you smoked?_____

How long has it been since you quit?_____

15. ☐ Yes ☐ No Do you drink caffeinated beverages? How much caffeine do you drink?_____

16. Please rate your daily average stress level.

☐ Low ☐ Moderate ☐ High: I enjoy the challenge
☐ High: sometimes difficult to handle ☐ High: often difficult to handle

17. Please select the following dietary habits you regularly follow.

☐ I seldom consume red or high-fat meats. ☐ I almost always eat a full, healthy breakfast.
☐ I pursue a low-fat diet. ☐ I rarely eat high-sugar or high-fat desserts.
☐ My diet includes many high-fiber foods. ☐ I take a multivitamin and mineral supplement.
☐ I eat at least 5 fruits/vegetables servings per day. ☐ I pursue a high protein, low carbohydrate diet.

18. Please indicate any other medical conditions or activity restrictions that you may have that are not previously mentioned. *It is important that this information be as accurate and complete as possible.*

_____

_____

I have read, understood and completed this questionnaire. I acknowledge, to the best of my ability, that I have answered the above questions completely and honestly. Any questions I had were answered to my full satisfaction.

_____ _____
Client Signature Date Staff Signature Date

_____ _____
Personal Representative's Signature Date Personal Representative's Relationship to Client