Health History Questionnaire

Please answer the following questions to the best of your ability. For the following questions, unless otherwise indicated, circle the single best choice for each question. As is customary, all of your responses are completely confidential. If you have any physical handicaps or limitations that would require special assistance with this questionnaire, please let your trainer know. This form is in accordance with the American College of Sports Medicine guidelines for risk stratification when followed correctly by your coach.

Name: _____ Ht: _____ Wt: _____

Gender: _____ Age: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone:_____

Emergency Contact: _____ Phone: _____

Personal Physician: _____ Phone: _____

E-mail: _____

1. Have you ever had a definite or suspected heart attack or stroke? ……..…… Yes No
2. Have you ever had coronary bypass surgery or any other type of heart surgery?…..…. Yes No
3. Do you have any other cardiovascular or pulmonary (lung) disease (***other than*** asthma, allergies, or mitral valve prolapse)? ……..…… Yes No
4. Do you have a history of: diabetes, thyroid, kidney, liver disease? ..…….…… Yes No
   (circle all that apply)
5. Have you ever been told by a health professional that you have had an abnormal resting or exercise (treadmill) electrocardiogram (EKG)? ……..……..…… Yes No

6. If you answered YES to any of Questions 1 through 5, please describe:

_____

_____

_____

_____

7. Do you currently have any of the following:
   a. Pain or discomfort in the chest or surrounding areas that occurs when you engage in physical activity ……..……..Yes No
   b. Shortness of breath ……..……..…..…Yes No
   c. Unexplained dizziness or fainting ….……..…..…Yes No
   d. Difficulty breathing at night except in upright position ……..…Yes No
   e. Swelling of the ankles (recurrent and unrelated to injury) ……..…Yes No
   f. Heart palpitations (irregularity or racing of the heart on more then one occasion) Yes No
   g. Pain in the legs that causes you to stop walking (claudication) …..……..…Yes No
   h. Known heart murmur …..……..……..……..…Yes No

Have you discussed any of the above with your personal Physician? ……..……Yes No

8. Are you pregnant or is it likely that you could be pregnant at this time? …….Yes No
   If yes, what is your expected due date?_____

9. Have you had surgery or been diagnosed with any disease in the past 3 months? Yes No
   If yes, please list date _____ and surgery/disease _____

10. Have you had high blood cholesterol or abnormal lipids within the past 12 months or are you taking medication to control your lipids? ……..……Yes No

11. Do you currently smoke cigarettes or have quit within the past 6 months? …….Yes No

12. Have you father or brother(s) had heart disease prior to age 55 OR mother or sister(s) had heart disease prior to age 65? ……..……..Yes No

13. Within the past 12 months, has a health professional told you that you have high blood pressure (systolic ≥ 140 OR diastolic ≥ 90)? ……..……..Yes No

14. Currently, do you have high blood pressure or within the past 12 months, have you taken any medicines to control your blood pressure? ……..……..Yes No

15. Have you ever been told by a health professional that you have a fasting blood glucose greater than or equal to 110 mg/dl? ……..……..…..Yes No

16. Describe your regular physical activity or exercise program:

    type: _____

    frequency: _____ days per week

    duration: _____ minutes

    intensity: *low* *moderate* *high* *(circle one)*

17. If you have answered YES to any of questions 7-16, please describe:

_____

_____

_____

18. Are you currently under any treatment for any blood clots? ……..…..Yes No

19. Do you have problems with bones, joints, or muscles that may be aggravated with exercise? ……..Yes No

20. Do you have any back/neck problems? ……..……..Yes No

21. Have you been told by a health professional that you should not exercise? …..Yes No

22. Are you currently being treated for any other medical condition by a physician? ..Yes No

23. Are there any other conditions (mitral valve prolapse, epilepsy, history of rheumatic fever, asthma, cancer, anemia, hepatitis, etc.) that may *hinder* your ability to exercise?…Yes No

24. During the past six months, have you experienced any *unexplained* weight loss or gain (greater than ten pounds for no known reason)? ……..….Yes No

25. If you have answer YES to any of questions 18-24, please describe:

    _____

    _____

    _____

26. Please list below all prescription and over-the-counter medications you are currently taking:

27. Are there any medicines that your physician has prescribed to you in the past 12 months which you are currently not taking?……..…..Yes No
    If so, please list:

    _____

    _____

    _____

I have answered the Health History Questionnaire questions accurately and completely. I understand that my medical history is a very important factor in the development of my coaching program. I understand that certain medical or physical conditions which are known to me, but that I do not disclose to my coach may result in serious injury to me. If any of the above conditions change, I will immediately inform my coach of those changes. I, knowingly and willingly, assume all risks of injury resulting from my failure to disclose accurate, complete, and updated information in accordance with the attached questionnaire.

Client's Signature: _____ Date: _____

All clients needing written medical clearance from their personal physician must give it to their coach prior to beginning their exercise program