

UWEC Community Fitness Program Health History Questionnaire

Name _____ Date _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email address _____ Date of Birth _____ Age _____

Personal Physician _____ Clinic _____

Date of Last Checkup _____ What is your usual occupation? _____

MEDICATIONS

What prescribed medications do you presently take? Why do you take them? Please write your dosage.

Medication	Dosage	Why Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What non-prescription medicines (over the counter) do you take and why? Please write your dosage.

Medication	Dosage	Why Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Are you allergic to or have you had a "bad reaction" to any medicines or other substances?

No

Yes → List the medicine/substance and the reaction

HEALTH HABITS

Do you currently smoke cigarettes? No Yes _____ packs/day, _____ # years

Have you ever smoke cigarettes? No Yes _____ packs/day, _____ # years

When did you quit? _____

On the average, how many cups/cans of the caffeine containing beverages do you consume per day?

_____ Tea _____ Coffee _____ Soda

On the average, how many alcoholic drinks do you have per day on weekdays? _____

on weekends? _____

Overall, how would you rate your diet? (Circle the appropriate number)

Unhealthy

1 2 3 4 5 6 7 8 9 10

Healthy

PHYSICAL ACTIVITY HISTORY

Have you ever had an exercise test? No

Yes Date of test _____
Location _____
If it was abnormal, explain _____

Are you aware of any physical limitation that would prevent you from exercising regularly?

No

Yes Please specify _____

Do you currently exercise on a regular basis?

No

Yes How many times per week? _____
How long per session? _____
Types of exercise _____

How would you rate your level of fitness?

Poor Fair Average Above Average Excellent

PERSONAL HISTORY

Have you ever had or do you currently have:

	YES	NO	When
Heart attack			
Open heart surgery			
Angioplasty			
Congenital heart problems			
Congestive heart failure (fluid in the lungs)			
Angina/chest pain, pressure, or discomfort			
Abnormal heart beats (palpitation)			
Heart murmurs			
FAMILY HISTORY of heart disease: Myocardial infarction (heart attack), bypass, or sudden death before 55yr (in father or other 1 st degree male relative), or before 65yr (in mother or other 1 st degree female relative).			
Stroke			
Rheumatic fever			
Thyroid problems			
Diabetes (IDDM, NIDDM)			
High blood pressure (hypertension)			
Swelling of the feet or ankles			
Cramping in the lower legs or feet with exertion			
Blackouts/fainting spells			
Shortness of breath at rest or with exertion			
COPD			
Asthma			
Bronchitis			
Emphysema			
Arthritis			
Low back pain			
Joint pain or swelling			
Other orthopedic problems (bad knees/hips, etc.)			
Emotional disorders			
Anxiety			
Depression			
Other			

If you answered yes to any of the above questions, please elaborate:

I hereby certify all statements provided by me in this questionnaire are complete and true to the best of my knowledge. Further, I give my permission to the UWEC Community Fitness Program staff to contact my personal physician or the program's medical director should there be questions or concerns about information in this medical history form.

Signature _____ Date _____