Medical History Questionnaire

This is your medical history form, to be completed prior to your first session. All information will be kept confidential. This information will be used for the evaluation of your health and readiness to begin our program. The form is extensive, but please try to make it as accurate and complete as possible. Please take your time and complete it carefully and thoroughly, and then review it to be certain you have not left anything out. Your answers will help us design a comprehensive program that meets your individual needs.

If you have questions or concerns, we will help you with those after this form is completed. We realize that some parts of the form will be unclear to you. Do your best to complete the form. Your questions will be thoroughly addressed afterwards. It might be helpful for you to keep a written list of questions or concerns as you complete the medical history form.

Name: ____

Date: ____

Name: ____

DOB: ________________________ SS#: ___ ___ ___-___ ___-___ ___ ___ ___ Sex: ___ M ___ F

Address: ____

City: _______________________________________ State: ___________ ZIP: ______________

Phone(s): Home: ____________________ Work: __________________ Cell: _________________

Email address: ____

Race: ____ White ____ Native American or Alaska Native
____ Black or African American ____ Native Hawaiian or other Pacific Islander
____ Asian ____ Decline to Provide
____ Other: ________________________________

Ethnicity: ____ Hispanic/Latino _____ Non-Hispanic/Non-Latino ____ Decline to Provide

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Education: ☐ Grade School ☐ Jr. High School ☐ High School ☐ College (2-4 years)
☐ Graduate School ☐ Degree ______________

Occupation: Employer: ____

Address: ____

City: _______________________________________ State: ___________ ZIP: ______________

Phone: _____________________________________ Position: ____________________________

Family Physician and/or Primary Health Care Provider:

Name: ____

Address: ____

City: _______________________________________ State: ___________ ZIP: ______________

Phone(s): ____

What is (are) your reasons (s) for participation in this Program?

☐ Rehydration to replace vital nutrients lost during exercise or illness.
☐ Other (please explain):

Present Medical History

Check those questions to which you answer yes (leave the others blank).

- ☐ Has a doctor ever said your blood pressure was too high?
- ☐ Do you ever have pain in your chest or heart?
- ☐ Are you often bothered by a thumping of the heart?
- ☐ Does your heart often race?
- ☐ Do you ever notice extra heartbeats 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 have or have had heart trouble, an abnormal electrocardiogram (ECG or EKG), heart attack or coronary?
- ☐ Do you suffer from frequent cramps in your legs?
- ☐ Do you often have difficulty breathing?
- ☐ 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?
- ☐ Has a doctor ever told you that you have an abdominal aortic aneurysm?
- ☐ Has a doctor ever told you that you have critical aortic stenosis?

Do you now have or have you recently experienced:
Check those questions to which you answer yes (leave the others blank).

- ☐ Chronic, recurrent or morning cough?
- ☐ Episode of coughing up blood?
- ☐ Increased anxiety or depression?
- ☐ Problems with recurrent fatigue, trouble sleeping or increased irritability?
- ☐ Migraine or recurrent headaches?
- ☐ Swollen, stiff or painful joints?
- ☐ Pain in your legs after walking short distances?
- ☐ Foot problems?
- ☐ Back problems?
- ☐ Stomach or intestinal problems, such as recurrent heartburn, ulcers, constipation or diarrhea?
- ☐ Significant vision or hearing problems?
- ☐ Recent change in a wart or a mole?
- ☐ Glaucoma or increased pressure in the eyes?
- ☐ Exposure to loud noises for long periods?
- ☐ An infection such as pneumonia accompanied by a fever?
- ☐ Significant unexplained weight loss?
- ☐ A fever, which can cause dehydration and rapid heart beat?
- ☐ A deep vein thrombosis (blood clot)?
- ☐ A hernia that is causing symptoms?
- ☐ Foot or ankle sores that won’t heal?
- ☐ Persistent pain or problems walking after you have fallen?
- ☐ Eye conditions such as bleeding in the retina or detached retina?
- ☐ Cataract or lens transplant?
- ☐ Laser treatment or other eye surgery?

WOMEN ONLY answer the following. Check those questions to which you answer yes (leave the others blank).

- ☐ Menstrual period problems?
- ☐ Significant childbirth - related problems?
- ☐ Urine loss when you cough, sneeze or laugh?
- ☐ Currently receiving hormone replacement therapy?
- ☐ Date of the last pelvic exam and/or Pap smear: ____

Past Medical History

Check those questions to which your answer is yes (leave others blank).

- ☐ Rheumatic Fever
- ☐ Heart murmur
- ☐ Diseases of the arteries
- ☐ Varicose veins
- ☐ Arthritis of legs or arms
- ☐ Diabetes or abnormal blood-sugar tests
- ☐ Phlebitis (inflammation of a vein)
- ☐ Dizziness or fainting spells
- ☐ Epilepsy or seizures
- ☐ Stroke
- ☐ Diphtheria
- ☐ Scarlet Fever
- ☐ Infectious mononucleosis
- ☐ Nervous or emotional problems
- ☐ Anemia
- ☐ Thyroid problems
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Asthma
- ☐ Abnormal chest X-ray
- ☐ Other lung disease
- ☐ Injuries to back, arms, legs or joint
- ☐ Broken bones
- ☐ Jaundice or gall bladder problems
- ☐ Heart attack if so, how many years ago? ___________________

List any prescription medications you are now taking:

List any self-prescribed medications, dietary supplements, or vitamins you are now taking:

Date of last complete physical examination: ____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Date of last chest X-ray: ____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Date of last electrocardiogram (EKG or ECG): ____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Date of last dental check-up: ____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

List any other medical or diagnostic test you have had in the past two years:

List hospitalizations, including dates of and reasons for hospitalization:

List any drug allergies:

Family Medical History

Father: ☐ Alive: Current age: ___________

☐ Deceased: Age at death: _________, cause of death: _____________________________

Mother: ☐ Alive: Current age: ___________

☐ Deceased: Age at death: _________, cause of death: ______________________________

Siblings: Number of brothers: ______ Number of sisters: ______ Age range: _______________

Significant health problems: ____

Familial Diseases

Have you or your blood relatives had any of the following (include grandparents, aunts and uncles, but exclude cousins, relatives by marriage and half-relatives)?

Check those questions to which your answer is yes (leave others blank).

- ☐ Heart attacks under age 50
- ☐ Strokes under age 50
- ☐ High blood pressure
- ☐ Elevated cholesterol
- ☐ Diabetes
- ☐ Asthma or hay fever
- ☐ Heart operations
- ☐ Glaucoma
- ☐ Obesity (20 or more pounds overweight)
- ☐ Leukemia or cancer under age 60
- ☐ Congenital heart disease (existing at birth but not hereditary)

Other Heart Disease Risk Factors

Have you ever smoked cigarettes, cigars or a pipe? ☐ Yes ☐ No (If no, skip to diet section)

Cigarettes, how many per day? _______________ Age started: ___________

Cigars, how many per day? __________________ Age started: ___________

Pipe, how many pipefuls a day? _____________ Age started: ___________

If you have stopped smoking, when was it? ____

Do you ever drink alcoholic beverages? ☐ Yes ☐ No If yes,

Beer: ☐ Occasional ☐ Often If often, _______ per week

Wine: ☐ Occasional ☐ Often If often, _______ per week

Hard Liquor: ☐ Occasional ☐ Often If often, _______ per week

Diet

What do you consider a good weight for yourself? ____lbs.

Most you have ever weighed (including pregnant)? _____________ lbs. How old were you? _______

My current weight is: _____________lbs. One year ago my weight was:_______________lbs.

Number of meals you usually eat per day: __________ Number of times per week you usually eat:

_____ Beef _____ Fish _____ Pork _____ Fowl _____ Fried Foods _____ Desserts

Number of servings (cups, glasses, or containers) per week you usually consume of:

_______ Skim (nonfat) milk _______ Homogenized (whole) milk _______ Buttermilk

_______ 2% (low-fat) milk _______ 1% (low-fat) milk _______ Coffee

_______ Tea (iced or not) _______ Regular or diet sodas _______ Water

Do you usually use oil or margarine in place of shortening or butter? ☐ Yes ☐ No

Do you usually abstain from extra sugar usage? ☐ Yes ☐ No

Do you usually add salt at the table? ☐ Yes ☐ No

Do you eat differently on weekends as compared to weekdays? ☐ Yes ☐ No