Health History Questionnaire
The College at Brockport – Exercise Science Employee Fitness Program

I. PERSONAL DATA:

Name ____________________________________________

Age ____ Birth Date:_________ Gender ___

Address __________________________________________

City ___________________________________________

State____ Zip _________

Phone: Home (____)____________ Cell (____)____________

E-Mail___________________________________

Occupation ____________________________________________

In case of emergency during testing, contact: Name _________________

Relation________________________

Phone _________________________
II. MEDICAL - SURGICAL HISTORY:
Check (√) if answer is yes. Have you ever had (if so, indicate date):

Date      Date
(  ) Rheumatic heart disease   (  ) Accidents
(  ) Heart Murmur            (  ) Chest pains
(  ) High Blood Pressure      (  ) Tightness in chest
(  ) Gout                     particularly during exercise
(  ) Varicose Veins           (  ) Shortness of breath
(  ) Lung Disease            (  ) Heart palpitations
(  ) Injuries to back         (  ) Excessive cough
(  ) Epilepsy                 (  ) Stroke
(  ) Diabetes                (  ) Heart Attack
(  ) Heart Surgery            (  ) Difficulty sleeping
(  ) Other Operations         (  ) Fatigue
(  ) Kidney Disease           (  ) Calf pain or cramps
(  ) Stomach Ulcers          with exercise
(  ) Arthritis                (  ) Nervousness
(  ) Hospitalizations        (  ) High Cholesterol
(  ) Cardiac Catheterization (  ) other problems

Please explain any checked answers and describe any illnesses, surgeries or diseases not listed above:
_______________________________________________________________________________________________________
_______________________________________________________________________________________________________
_______________________________________________________________________________________________________

III. MEDICATIONS:
Please list medications that you are presently taking.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Reason for taking</th>
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IV. PRESENT HEALTH

What do you consider your present overall state of health to be? __________

If your overall health is not good what is your major complaint or problem and when did the symptoms begin? ____________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Have you ever sprained, strained, severely bruised, dislocated, broken, or had chronic pain to any of the following bones or joints? (please circle all that apply)

Jaw  Neck  Shoulder  Elbow  Wrist

Back  Hip  Knee  Ankle  Foot

Shin/calf  Thigh  Arm  Other: __________

Explain all circled answers:__________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Do you smoke? Yes ______ No_______ If yes, ______ per day for _____ years.

Do you follow a special diet? If yes, please describe________________________________________

_______________________________________________________________________________

Do you drink alcoholic beverages? If yes, _____ per week.
V. FAMILY MEDICAL HISTORY:

To your knowledge, have any of your relatives had any of the following?:

<table>
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<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Relative (Who?)</th>
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<tbody>
<tr>
<td>Cancer</td>
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<td>Diabetes</td>
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<td>Heart Disease</td>
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<tr>
<td>High blood pressure</td>
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<td>High Cholesterol</td>
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<tr>
<td>Stroke</td>
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<tr>
<td>Peripheral vascular disease</td>
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VI. CURRENT EXERCISE REGIMEN:

Briefly describe any regular cardiovascular/aerobic exercise that you participate in:

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<tr>
<th>Type of exercise</th>
<th>Number of times/week</th>
<th>Number of minutes/session</th>
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Do you use machines (e.g., Nautilus, Cybex) or free weights? (Please circle one or both)

Briefly describe any regular resistance training (weight lifting) that you participate in:

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VII. GOALS FOR HEALTH AND FITNESS:

Please indicate what your health and fitness related goals are. Be as specific as possible. For example: 1) lower my cholesterol by 20 points, 2) Lose 15 pounds in 4 months, and 3) run a 5km race in less than 30 minutes.

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