University Recreation
Health History Questionnaire

NAME_____ TODAY'S DATE_____

E-MAIL_____ TELEPHONE_____

BIRTH DATE_____ AGE_____GENDER___ WEIGHT____ HEIGHT____

1) Has a physician ever told you that you have had any of the following?

_____	Coronary Heart Disease	_____	Heart Attack
_____	Rheumatic Disease	_____	Stroke
_____	Congenital Heart Disease	_____	Epilepsy
_____	Irregular Heartbeats	_____	Diabetes
_____	Heart Valve Problems	_____	Angina
_____	Heart Murmurs	_____	Cancer
_____	High Blood Pressure	_____	Arthritis
_____	High Cholesterol	_____	Obesity
_____	Lung Disease (Asthma, Emphysema, etc.)		
_____	Other		

Please explain: _____
_____

2) Has anyone in your immediate family (mother, father, siblings, grandparents) experienced any of the above conditions?
_____NO _____YES

3) Do you ever experience any of the following?
_____ Chest Pain/Discomfort
_____ Shortness of Breath
_____ Heart Palpitations
_____ Back Pain
_____ Joint, Tendon, or Muscular Pain
_____ Orthopedic Problems

If yes, please explain: _____
_____

4) Please list any medications that you are currently taking (name & reason): _____
_____
_____

5) Do you have any medical conditions for which a physician has ever recommended some restrictions on activity (including surgery)?
_____NO _____YES
If yes, please explain: _____
_____

6) Are you pregnant? _____NO _____YES

7) Do you smoke? _____NO _____YES
_____ Cigarettes per day
_____ Pipes per day
_____ Cigars per day
Do you use smokeless tobacco? _____NO _____YES

8) Have you had your cholesterol measured in the last year?
_____NO _____YES
If yes, what was the value? _____

9) Do you drink alcoholic beverages at all? _____NO _____YES
If yes, how many drinks per week? _____

10) Do you eat a variety from the major food groups (meats, fruits, vegetables, grains, milk)?
_____NO _____YES

11) Is your diet high in saturated fat (milk products, cheese, meats, fried foods, desserts)?
_____NO _____YES

12) Check the description that bests represents the amount of stress you experience on a daily basis.
_____ No stress
_____ Occasional mild stress
_____ Frequent moderate stress
_____ Frequent high stress
_____ Constant high stress

13) Have you had a recent weight loss or gain? If so, how much?_____

14) Please describe your current exercise program. List type of activity, number of sessions per week, time per sessions and intensity level:
_____
_____
_____
_____

15) List any areas for which you would like additional information:
_____
_____
_____
_____