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:

_____________________________________________________________________
_____________________________________________________________________