NCH Wellness Center Health History Questionnaire

First Name _____________________ Last Name _____________________ Date: ________________

Emergency Contact Name________________________ Emergency Contact Phone_________________

Have you ever had any of the following?

- Heart Attack □ YES □ NO
- Angina □ YES □ NO
- Asthma □ YES □ NO
- Anemia □ YES □ NO
- Osteoporosis □ YES □ NO
- Heart Surgery □ YES □ NO
- Rheumatic Fever □ YES □ NO
- Emphysema □ YES □ NO
- Emboli (blood clot) □ YES □ NO
- Coronary Artery Disease □ YES □ NO
- Stroke □ YES □ NO
- Cancer □ YES □ NO
- Pulmonary Disease □ YES □ NO
- Heart Valve Problems □ YES □ NO
- Phlebitis (vein inflammation) □ YES □ NO
- Currently Pregnant □ YES □ NO

Please list all known allergies: _____________________________________________________________

Please list any conditions not noted above: ___________________________________________________

If you answered “yes” to any of the above Medical Diagnoses, it is STRONGLY RECOMMENDED that you consult your physician before beginning your exercise program.

Are you a male over the age of 45 or a female over the age of 55? □ YES □ NO

Had a hysterectomy or are postmenopausal?
□ YES □ NO □ N/A

Has your father or brother experienced a heart attack before the age of 55 or has your mother or sister experienced a heart attack before the age of 65? Relation: ________________
□ YES □ NO

Has your doctor ever told you that you might have high blood pressure?
□ YES □ NO

Do you have cholesterol above 200ml/dl?
□ YES □ NO

Do you have impaired fasting glucose (diabetes)?
□ YES □ NO

Are you physically inactive? (i.e., you get less than 30 min of physical activity on at least 3 days per week.)
□ YES □ NO

Do you currently smoke or have you quit smoking within the last 6 months?
□ YES □ NO

Are you more than 20 pounds overweight?
□ YES □ NO

If you are a male over the age of 45 or a woman over the age of 55 OR if you answered “YES” to two (2) or more of the above Major Risk Factors, it is STRONGLY RECOMMENDED that you receive physician’s clearance before beginning your exercise program.
Do you have any of the following?

- Pain/discomfort (or angina equivalent) in the chest/neck/jaw/arms/other areas
- Shortness of breath at rest or with mild exertion
- Dizziness or fainting with rest or mild exertion
- Labored breathing at rest or with mild exertion
- Edema (excessive accumulation of tissue fluid)
- Palpitations or tachycardia (sudden rapid heartbeat)
- Intermittent claudication (lameness due to decreased blood flow)
- Known heart murmur (abnormal heart sound)
- Unusual fatigue or shortness of breath with usual activities

□ YES □ NO

Cardiovascular: cardiac, peripheral vascular, cerebro-vascular disease
Pulmonary: chronic obstructive pulmonary disease, asthma, interstitial lung disease, cystic fibrosis
Metabolic Disease: Diabetes Mellitus (Type I & II), thyroid disorders, renal or liver disease

If you answered “YES” to any of the Signs & Symptoms listed above OR have known cardiovascular, pulmonary, or metabolic disease (as defined above), it is STRONGLY RECOMMENDED that you receive physician’s clearance before beginning your exercise program.

I understand this Health History Questionnaire has been provided to me for the purpose of helping me better understand any potential risks associated with an exercise program. I also understand that I should share this information with my physician and seek his or her approval prior to beginning an exercise program. I understand the information I have provided will be maintained in my membership file for use in case of a medical emergency. My signature signifies that all of the above is true, to the best of my knowledge. Any information left unanswered was done so intentionally. If any of the above information changes, I agree to submit these changes in writing to this facility’s wellness professional for an update to my membership file.

Signature: ___________________________ Date: ____________
Wellness Representative Signature: ___________________________ Date: ____________

I understand this Health History Questionnaire has been provided to me for the purpose of helping me better understand any potential risks associated with a workout program, to share with my physician in order to obtain his or her approval before beginning an exercise program, and to be maintained as part of my membership file in case of a medical emergency. I do not want to complete this questionnaire and understand that I assume full responsibility for any risks associated with my participation in an exercise program.

Signature: ___________________________ Date: ____________
Wellness Representative Signature: ___________________________ Date: ____________