Briggs Wellness Center
399 Ninth St N., Naples, FL 34102
PH: (239) 624-2750 - Fax: (239) 624-2751
WellnessEnrollments@nchmd.org

NCH Healthcare System
Wellness & Fitness Centers

Whitaker Wellness Center
2330 Immokalee Rd., Ste 1, Naples, FL 34110
PH: (239) 624-6870 Fax: (239) 624-6871
WellnessEnrollments@nchmd.org

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

Are you a female who has 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	☐ YES	☐ NO
Shortness of breath at rest or with mild exertion	☐ YES	☐ NO
Dizziness or fainting with rest or mild exertion	☐ YES	☐ NO
Labored breathing at rest or with mild exertion	☐ YES	☐ NO
Edema (excessive accumulation of tissue fluid)	☐ YES	☐ NO
Palpitations or tachycardia (sudden rapid heartbeat)	☐ YES	☐ NO
Intermittent claudication (lameness due to decreased blood flow)	☐ YES	☐ NO
Known heart murmur (abnormal heart sound)	☐ YES	☐ NO
Unusual fatigue or shortness of breath with usual activities	☐ YES	☐ NO
Cardiovascular: cardiac, peripheral vascular, cerebro-vascular disease	☐ YES	☐ NO
Pulmonary: chronic obstructive pulmonary disease, asthma, interstitial lung disease, cystic fibrosis	☐ YES	☐ NO
Metabolic Disease: Diabetes Mellitus (Type I & II), thyroid disorders, renal or liver disease	☐ YES	☐ NO

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 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 <u>do not</u> 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: _____

Note: All Major Risk Factors, Signs and Symptoms classifications are taken directly from Whaley, Mitchell H, ed. *ACSM's Guidelines for Exercise Testing and Prescription.* Philadelphia, PA: Lippincott Williams & Wilkins, 2006.