HEALTH HISTORY QUESTIONNAIRE

General Information

Last ____________________________________ First ______________________ MI____

Phone __________________________________ Email _______________________________

Date of Birth _____________________________ Height __________ Weight ________

Age _____________ Gender ☐ Male ☐ Female ☐ Transgender/Non-Binary

Medical Care Information

Physician Name _________________________ Phone ______________________________

Clinic Name _____________________________ Fax ________________________________

Emergency Contact Information

Name __________________________________ Phone ______________________________

Please check all true statements about you that apply.

Experiencing these Symptoms

☐ chest discomfort with exertion
☐ unreasonable breathlessness
☐ dizziness, fainting or blackouts
☐ ankle swelling
☐ unpleasant awareness of a forceful, rapid or irregular heart rate
☐ burning or cramping sensation in your lower legs when walking short distances
☐ **None of the above**

Current Physical Activity

Planned, structured physical activity at moderate intensity (noticeable increase in breathing and heart rate) in the last 3 months

Days per week

☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-7

Duration (in minutes)

☐ <10 ☐ 11-30 ☐ 31-60 ☐ 60+

Medical Conditions – You have had:

- ☐ a heart attack
- ☐ heart surgery, cardiac catheterization or coronary angioplasty
- ☐ pacemaker/implantable cardiac defibrillator/rhythm disturbance
- ☐ heart valve disease
- ☐ heart failure
- ☐ heart transplantation
- ☐ congenital heart disease
- ☐ diabetes
- ☐ renal disease
- ☐ stroke or cerebrovascular disease
- ☐ peripheral vascular disease
- ☐ **None of the above**

Health Issues

- ☐ asthma, bronchitis, pneumonia, emphysema or other lung disease
- ☐ arthritis
- ☐ smoker
- ☐ parkinson's
- ☐ osteoporosis
- ☐ MS
- ☐ fibromyalgia
- ☐ balance challenges or falls
- ☐ prediabetes
- ☐ currently pregnant or less than six weeks post-partum
- ☐ cancer, diagnosed ≤ 12 months Yes No
- ☐ musculoskeletal problems limiting your physical activity ______________________________
- ☐ recent surgeries ____
- ☐ **None of the above**

Stress

Amount of stress you experience on a daily basis

- ☐ no stress, easy going
- ☐ occasional stress
- ☐ frequent moderate stress
- ☐ constant high stress

Care Giver needed ☐ Yes ☐ No

Mobility Limitations ____

Currently experiencing musculoskeletal or health issues not listed above

____

____

I understand that completion of the health history questionnaire and risk stratification is required prior to starting my exercise program. I certify that all of the information I have provided on this form is true and accurate. I will notify OHSU march wellness & fitness center of any changes in my health status.

____ ______________________________

Member Signature Date

Comments ____

ACSM Risk Stratification PA Needed ☐ Yes ☐ No Staff Initials ____________________