3239 Sunset Blvd.,West Columbia, SC 29169
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Health History Questionnaire

Name:_______________________________Date: _______ Age: _____ Gender: M __ F__Ht_____ Wt_____

Regular physical activity is safe for most people. However, some individuals should check with their doctor before they start an exercise program. To help us determine if you should consult with your doctor before starting to exercise with Health Directions, please read the following questions carefully and answer each one honestly. All information will be kept confidential.

Please Circle Yes or No:
1. Are you currently experiencing any health problems? Yes No If yes, please describe:_________________
____

2. Do you smoke? Yes No If yes, specify how long and how much: _________________________________

3. Do you have high blood pressure? Yes No Last reading: _______ Date:______Medication_____________

4. Do you have high cholesterol? Yes No Last reading: _______ Date:______Medication_____________

5. Have you been doing some type of exercise on regular basis (2-3x's per week) over the last year? Yes No
If yes, please be specific: ____

6. Do you have a family history of heart disease prior to age 55? Yes No
If yes, specify relationship and age____

7. Please answer the following questions regarding your health:

Yes No Heart Disease (be specific)__________________________Medication ___________________
Yes No Diabetes (onset) __/__/__ Medication__________________Diet only? Yes No
Yes No Stroke __/__/__ Medication ________________________________
Yes No Asthma (Medication) ____
Yes No Epilepsy (Medication) ____
Yes No Back Injury (be specific)___________________________Medication/Treatment___________________
Yes No Orthopedic problems (be specific)___________________Medication/Treatment___________________
Yes No Arthritis/Bursitis (be specific)_____________________ Medication/Treatment___________________
Yes No Muscular weakness or injuries ______________________ Medication/Treatment___________________
Yes No Allergies:_____________________________________Medication/Treatment___________________
Yes No Other medical problems__________________________ Medication/Treatment___________________
Yes No Do you take any over-the-counter medications regularly? Please list:______________________________

8. Please circle if you experience any of the following: Chest pain Ankle swelling Shortness of breath Dizziness
Heart murmur Fainting Irregular heartbeat (medications): _____________________________

9. Have you ever had an abnormal EKG? Yes No Date of most recent EKG:___/___/___

10. Any major illness or hospitalization within the last 6 months? Yes No If yes, please specify:___________________
____

11. Have you had a medical examination in the past year? Yes No Date: __/__/__
12. Are you pregnant? Yes No Due Date: __/__/__

____
Member Signature

Staff Use Only:
Reviewed by: _____________________________Date:__________
ACSM Risk Stratification: Low Moderate High Medical Release Requested: Yes No BMI_____