

Health History Questionnaire

Exercise
is Medicine®

AMERICAN COLLEGE
of SPORTS MEDICINE®

Name: _____ Date of birth: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (Cell): _____ (Work): _____ Email address: _____

In case of emergency, whom may we contact?

Name: _____ Relationship: _____

Phone (Cell): _____ (Home): _____

Health Care Provider: _____

Name: _____ Phone: _____ Fax: _____

Present/Past History

Have you had, or do you presently have any of the following? (Check if yes.)

- | | |
|---|--|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Fainting or dizziness |
| <input type="checkbox"/> Any kind of heart disease or heart surgery | <input type="checkbox"/> Chest pains |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Palpitations or tachycardia (unusually strong or rapid heartbeat) |
| <input type="checkbox"/> Prediabetes | <input type="checkbox"/> Known heart murmur |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Muscle or joint problems (e.g., back, knee) |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Edema (swelling of ankles) |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Pain, discomfort in the chest, neck, jaw, arms, or other areas |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Unusual fatigue or shortness of breath at rest or with light activity |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Temporary loss of clear vision or speech or short-term numbness or weakness in one side, arm, or leg of your body |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Shortness of breath while lying down, at night or that comes on suddenly |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Intermittent claudication (calf cramping) |
| <input type="checkbox"/> Rheumatic fever | |
| <input type="checkbox"/> Recent operation | |
| <input type="checkbox"/> Other (please describe): _____ | |
| _____ | |
| _____ | |

Family History

Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions? (Check if yes.) In addition, please identify at what age the condition occurred.

- | | |
|---|---|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Heart surgery |
| <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Other major illness: _____ |
| <input type="checkbox"/> High cholesterol | |

Explain checked items:

Activity History

1. Why have you decided to seek exercise guidance at this time? (Please be specific.)
2. Were you referred to this program? Yes By whom: _____ No
3. Have you ever worked with a personal trainer before? Yes No
4. Date of your last physical examination performed by a physician:
5. Do you participate in a regular exercise program currently? Yes No
If yes, briefly describe:
6. Can you currently walk 2 miles briskly without fatigue? Yes No
7. Have you ever performed strength training exercises in the past? Yes No
8. Do you have injuries (bone/muscle disabilities) that may interfere with exercising? Yes No
If yes, briefly describe:
9. Do you smoke? Yes No
If yes, how much per day and what was your age when you started?
10. What is your body weight now?
What was it one year ago?
At age 21?
11. How tall are you?
12. Do you follow, or have you recently followed any specific dietary intake plan and, in general, how do you feel about your nutritional habits?
13. List the medications you are presently taking.
14. What are your personal health or fitness goals?