Health History Inventory

(Long Version)

Please answer each of the questions in this inventory to the best of your ability. For each question, please mark the best choice, unless otherwise indicated. In some instances, you will need to write out your response. If you need assistance with answering any of these questions, please request assistance from a fitness professional. All of your responses will be treated in a confidential manner.

GENERAL INFORMATION

Name:_____

Gender: ❑ Male ❑ Female Birth Date:_____ Height:_____ ft. _____ inches Weight:_____ pounds

Address:_____

City:_____ State:_____ ZIP:_____

Phone (office):_____ Phone (cell):_____

Phone (home):_____ E-mail:_____

Marital Status:_____ Highest Level of Education Attained:_____

Occupation:_____

Primary Care Physician:_____

Address:_____

City:_____ State:_____ ZIP:_____

Phone (office):_____

Program Goals (i.e., your training objectives):_____

_____

_____

PART I: PAST MEDICAL HISTORY

1. Have you ever been told by a doctor that you have or had heart problems, an abnormal EKG, or had a heart attack or stroke?	❑ Yes	❑ No
2. Have you ever had coronary by-pass surgery, angioplasty, or any other type of heart surgery?	❑ Yes	❑ No
3. Have you ever had difficulty breathing or become short of breath with mild or light exertion?	❑ Yes	❑ No
4. Do you have a history of diabetes or thyroid, kidney, or liver disease?	❑ Yes	❑ No
5. Have you ever experienced irregular heartbeat (arrhythmia) or been diagnosed with a heart condition or disease?	❑ Yes	❑ No

6. If you answered YES to any of the above questions, please provide additional information below:

_____

_____

_____

PART II: CURRENT MEDICAL HISTORY

7. Do you currently experience or have any of the following:

a. Pain or discomfort in the chest or surrounding areas that occurs when you engage in exercise or physical activity?	❑ Yes	❑ No
b. Shortness of breath with activity or at rest?	❑ Yes	❑ No
c. Unexplained dizziness or fainting?	❑ Yes	❑ No
d. Difficulty breathing at night, except in an upright position?	❑ Yes	❑ No
e. Swelling in the ankles or lower extremities (other than due to an injury)?	❑ Yes	❑ No
f. Heart palpitations (rapid or irregular heart beat of the heart)?	❑ Yes	❑ No
g. Pain in the legs that may cause you to stop walking?	❑ Yes	❑ No
h. Known heart murmur?	❑ Yes	❑ No

8. Are you pregnant or is it likely that you may become pregnant at this time?_____ ❑ Yes ❑ No
   If you are pregnant, what is your expected due date?_____

9. Have you had surgery, or been diagnosed with any disease in the past three months? ❑ Yes ❑ No
   If you answered yes to question 9, please list the date _____
   And nature of the surgery/disease: _____

10. In the past 12 months, have you been told by a healthcare professional that you have an elevated cholesterol level or abnormal lipid profile, or are you on any medications to control your blood lipids? ❑ Yes ❑ No

11. Do you currently smoke cigarettes, or have you quit within the past six months? ❑ Yes ❑ No

12. Have your father or brother(s) had heart disease prior to the age of 55 or mother or sister(s) had heart disease prior to age 65? ❑ Yes ❑ No

13. Within the past 12 months, has a healthcare professional told you that you have high blood pressure? (systolic >140 mmHg, diastolic >90 mmHg) ❑ Yes ❑ No

14. Do you currently have high blood pressure, or are you taking medication(s) to manage high blood pressure? ❑ Yes ❑ No

15. Within the past 12 months, have you been told by a healthcare professional that you have an elevated fasting blood glucose level? (>100 mg/dl) ❑ Yes ❑ No

16. Are you currently under the care of a healthcare professional for blood clots or other circulatory problems? ❑ Yes ❑ No

17. Do you currently experience problems or pain in your bones, joints, or muscles that may be aggravated with exercise? ❑ Yes ❑ No

18. Do you currently experience any back and/or neck discomfort or problems? ❑ Yes ❑ No

19. Are you currently under the care of a healthcare professional for any other health/medical problems? ❑ Yes ❑ No

20. If you have answered YES to any of the questions in part II (questions 7–19), please provide additional information below:

_____

_____

21. Please list below all prescription and over-the-counter medications you are currently taking?

Medicine	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

22. Are there any medications that your physician and/or healthcare professional have prescribed for you in the past 12 months that you are currently not taking? ❑ Yes ❑ No
    If you answered yes, please list the medications? _____

PART III: PHYSICAL ACTIVITY/EXERCISE HISTORY

23. Please list any favorite activities you would like to include in your exercise plan.

_____

_____

24. Please list any activities you dislike or do not want to include in your exercise plan.

_____

_____

25. Please list any fitness activities (e.g., jogging, cycling, strength training) that you participate in regularly (include how often, how hard, and how long).

_____

_____

26. Please list any recreational activities (e.g., golf, tennis) that you participate in regularly (include how often).

27. Where do you plan to exercise (e.g., club, home, outdoors)?

28. If you plan to exercise at home, list all available equipment.

29. Have you been told by a healthcare professional that you should not exercise? ❑ Yes ❑ No

30. If you answered YES to question #29 in part III, please describe below:

PART IV: WEIGHT HISTORY

31. What do you consider to be your ideal body weight? _____

32. What has been your lowest body weight as an adult (list how old you were)? _____

33. What has been your highest body weight as an adult (list how old you were)? _____

34. What is your current weight? _____

35. What was your weight one year ago? _____

PART V: DIET/NUTRITION HISTORY

36. How many meals do you typically eat per day? _____

37. Do you eat a variety of foods from each of the food groups? ❑ Yes ❑ No

38. Do you try to limit the amount of fat you eat to <30% of your total daily caloric intake? ❑ Yes ❑ No

39. Do you use sugar sparingly by adding little or none to the foods you eat and by limiting your intake of desserts, candy, and soft drinks? ❑ Yes ❑ No

40. Do you limit your alcohol consumption to 1–2 drinks or fewer per day? ❑ Yes ❑ No

41. If you answered NO to any of the questions in part V (questions 37–40), please describe below:

I have answered the questions in this Health History Inventory to the best of my ability, and as accurately and completely as possible. I understand that this information is kept strictly confidential and is used only for the purpose of helping the health/fitness professional make the most appropriate recommendations and design a safe and effective physical-activity program to meet my unique needs. Furthermore, I understand that this information cannot be released to any other party without my prior written approval in accordance with the Health Insurance Portability and Accountability Act of 1996. I understand that my failure to disclose health, medical, or related information that might affect my participation in physical activity may limit the ability of the health/fitness professional to provide the safest possible physical-activity program. Finally, I understand that the information collected in this Health History Inventory has been designed using the recommendations provided by the American College of Sports Medicine for risk stratification as described in their publication, *ACSM's Guidelines for Exercise Testing and Prescription*, 7th edition (2006).

Client/member signature:_____ Date:_____

Staff/trainer signature:_____ Date:_____