

Health & Medical Status Questionnaire

Please answer every question as accurately as possible so that a correct assessment can be made. Place a check in the box next to any questions that you are responding to with a "yes". If the answer is "No", please leave the box blank. Your responses will be treated in a confidential manner.

Today's Date Name Sex M F Age(yrs)

- Do you have any personal history of heart disease (coronary or atherosclerotic disease)?
- Any personal history of diabetes or other metabolic disease (thyroid, renal, liver)?
- Any personal history of pulmonary disease, asthma, interstitial lung disease or cystic fibrosis?
- Any personal history of gout, arthritis or other inflammatory conditions?
- Have you experienced pain or discomfort in your chest apparently due to blood flow deficiency?
- Any unaccustomed shortness of breath (perhaps during light exercise)?
- Have you had any problems with dizziness or fainting?
- Do you have difficulty breathing while standing or sudden breathing problems at night?
- Have you experienced a rapid throbbing or fluttering of the heart?
- Do you suffer from ankle edema (swelling of the ankles)?
- Have you experienced severe pain in leg muscles during walking?
- Do you have a known heart murmur?
- Has your serum cholesterol been measured at greater than 200 mg/dl?
- Has your HDL (the "good" cholesterol) been measured at greater than 60 mg/dl?
- Are you a cigarette smoker?
- Would you characterize your lifestyle as "sedentary"?
- Have you had a high fasting blood glucose level on 2 or more occasions (≥ 110 mg/dl)?
- Are you 20% or more overweight or have you been told your "BMI" was greater than 30?
- Have you been assessed as hypertensive on at least 2 occasions (systolic > 140 mmHg or diastolic > 90 mmHg)?
- Are you a male over the age of 44 or a female over the age of 54?
- Are you a post menopausal woman?
- Are you pregnant or have you had a baby in the past 3 months?
- Have you had surgery in the past 3 months?
- Are you currently being treated for high blood pressure?

If you know your average blood pressure, please enter: /

Please check all conditions or diagnoses that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> Abnormal EKG? | <input type="checkbox"/> Limited Range of Motion? | <input type="checkbox"/> Stroke? |
| <input type="checkbox"/> Abnormal Chest X-Ray? | <input type="checkbox"/> Arthritis? | <input type="checkbox"/> Do You Suffer from Epilepsy or Seizures? |
| <input type="checkbox"/> Rheumatic Fever? | <input type="checkbox"/> Bursitis? | <input type="checkbox"/> Chronic Headaches or Migraines? |
| <input type="checkbox"/> Low Blood Pressure? | <input type="checkbox"/> Swollen or Painful Joints? | <input type="checkbox"/> Persistent Fatigue? |
| <input type="checkbox"/> Asthma? | <input type="checkbox"/> Foot Problems? | <input type="checkbox"/> Stomach Problems? |
| <input type="checkbox"/> Bronchitis? | <input type="checkbox"/> Knee Problems? | <input type="checkbox"/> Hernia? |
| <input type="checkbox"/> Emphysema? | <input type="checkbox"/> Back Problems? | <input type="checkbox"/> Anemia? |
| <input type="checkbox"/> Other Lung Problems? | <input type="checkbox"/> Shoulder Problems? | <input type="checkbox"/> Are You Pregnant? |
| | <input type="checkbox"/> Recently Broken Bones? | |

Has a doctor imposed any activity restrictions? If so, please describe:

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When did you have your last medical exam

Please elaborate on any checked items above:

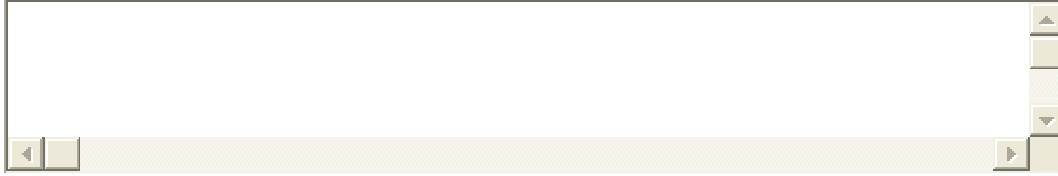
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Family History

Have your mother, father, or siblings suffered from (please select all that apply):

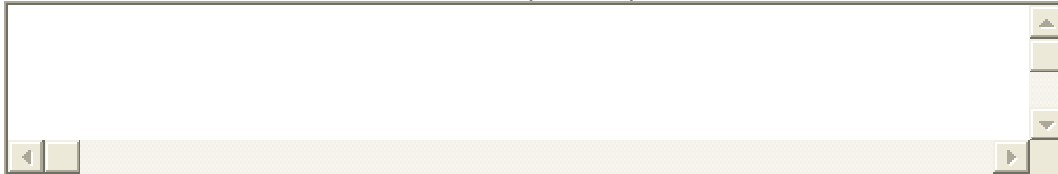
- | | |
|--|--|
| <input type="checkbox"/> Heart attack or surgery prior to age 55. | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Stroke prior to age 50. | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Congenital heart disease or left ventricular hypertrophy. | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Leukemia or cancer prior to age 60. |

Please list the specific medications that you currently take:

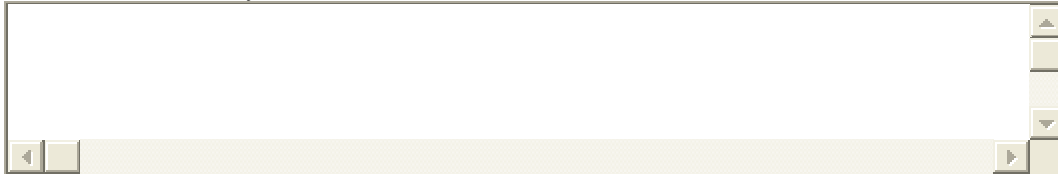


Other:

Please Indicate Any Other Medical Conditions or Activity Restrictions That You May Have. It is important that this information be as accurate and complete as possible



Is any of this information critical to understanding your readiness for exercise? Are there any other restrictions on activity that we should know about?



Thank you for taking the time to complete this questionnaire.