

Health History Questionnaire

Waterford Health & Fitness Club

1000 West Century Avenue Bismarck, ND 58503-0913 · 701-355-1280 · 701-221-2525 Fax

Date:

PERSONAL INFORMATION

Name:

Phone Day:

Phone Evening:

Email:

Date of Birth:

Age:

Emergency contact Name & Phone:

Are you a Waterford Resident?

Gender:

Yes No

Male Female

PHYSICIAN/PROVIDER INFORMATION

Please provide physician/provider information below. According to the American College of Sports Medicine, it may be necessary to get a physician clearance prior to starting your workout program. You have up to thirty (30) days from Waterford's initial call to set up the appointment. Please refer to the member handbook Optional Functional Fitness Profile section.

Name:

Clinic:

Phone:

Fax:

HEALTH HISTORY (Check all that apply) *

- | | | |
|---|--|---|
| <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Bypass or cardiac surgery | <input type="checkbox"/> Hyper or hypothyroidism |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> History of stroke | <input type="checkbox"/> Infectious mononucleosis |
| <input type="checkbox"/> Heart disease aggravated by activity | <input type="checkbox"/> History of cancer or lymphedema | <input type="checkbox"/> Dizziness/Vertigo/Fainting |
| <input type="checkbox"/> Heart attacks | <input type="checkbox"/> Palpitations of tachycardia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Neurological/MS/Parkinson's | <input type="checkbox"/> Pacemaker or IACD |
| <input type="checkbox"/> Bone or joint condition | | <input type="checkbox"/> None of the above |

Other (Please list below)

*If you checked any of the above statements in this section, consult your healthcare provider before engaging in exercise.

CURRENT/RELEVANT HEALTH DATA (Check all that apply) *

- | | | |
|--|--|--|
| <input type="checkbox"/> Female over 55 | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Irregular heartbeat |
| <input type="checkbox"/> Premature menopause without hormone | <input type="checkbox"/> Don't know resting blood pressure | <input type="checkbox"/> Current smoker |
| <input type="checkbox"/> Hysterectomy prior to menopause | <input type="checkbox"/> Diagnosed high blood pressure (above 140/90) | <input type="checkbox"/> Former smoker-quit less than 10 years ago |
| <input type="checkbox"/> Currently pregnant or less than six weeks post-partum | <input type="checkbox"/> Currently taking blood pressure medication | <input type="checkbox"/> Diagnosed high cholesterol (above 240mg/dL) |
| <input type="checkbox"/> Male over 45 | <input type="checkbox"/> Currently taking medications for congestive heart disease | <input type="checkbox"/> Leg length difference |
| <input type="checkbox"/> Exercise less than three times a week, less than 30 minutes | <input type="checkbox"/> Known abnormal blood sugar | <input type="checkbox"/> Cold hands/feet |
| <input type="checkbox"/> Do not currently exercise | <input type="checkbox"/> Shortness of breath while performing normal activities | <input type="checkbox"/> Numbness or tingling in extremities |
| <input type="checkbox"/> Currently 20 pounds over ideal weight | <input type="checkbox"/> Experiencing frequent light headedness or fainting | <input type="checkbox"/> Currently using continence products |
| <input type="checkbox"/> Shortness of breath when exercising | <input type="checkbox"/> Physician currently restricting activity level | <input type="checkbox"/> None of the above |

Diagnosed with Diabetes Diabetes type: _____

Total Cholesterol:

Which of the following apply to your parents, brothers or sisters?

- Heart attack or cardiac related surgery prior to 50 years of age Strokes prior to 50 years of age

*If you marked two or more statements in the above section, consult your healthcare provider before engaging in exercise.

HISTORY OF HEALTH PROBLEMS (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Foot problems | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Migraine/headaches | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Increased anxiety |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Knee problems | <input type="checkbox"/> Stomach or intestinal problems |
| <input type="checkbox"/> Swollen or stiff joints | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Back problems | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Unusual fatigue |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Broken bones | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Abnormal chest x-ray | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> None of the above |

If any are current, please comment:

EXERCISE HISTORY

Are you presently exercising a minimum of three times per week for at least 30 minutes at a time?

- Yes No

If yes, please specify:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Running/Jogging | <input type="checkbox"/> Cross country ski | <input type="checkbox"/> Aerobic dance | <input type="checkbox"/> Raquet sports |
| <input type="checkbox"/> Biking | <input type="checkbox"/> Swimming | <input type="checkbox"/> Brisk walking | <input type="checkbox"/> Weight training |
| <input type="checkbox"/> Golf | | | |

Other (Please specify)

Total minutes engaged in cardiovascular activity per week:

- | | | |
|--|---|--|
| <input type="checkbox"/> 0-20 minutes | <input type="checkbox"/> 21-40 minutes | <input type="checkbox"/> 41-60 minutes |
| <input type="checkbox"/> 61-80 minutes | <input type="checkbox"/> 81-100 minutes | <input type="checkbox"/> 100+ minutes a week |

What are your fitness goals for joining the Waterford Health and Fitness Club? Please indicate all that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> To lose weight | <input type="checkbox"/> To improve muscle conditioning | <input type="checkbox"/> To lower cholesterol |
| <input type="checkbox"/> To improve cardiovascular fitness | <input type="checkbox"/> To reduce low back pain | <input type="checkbox"/> To improve nutrition |
| <input type="checkbox"/> To improve flexibility | <input type="checkbox"/> To reduce stress | <input type="checkbox"/> To feel better overall |
| <input type="checkbox"/> To stop cigarette smoking | <input type="checkbox"/> To improve functional fitness | |

Other (Please specify)

Check the description that best represents the amount of stress that you experience on a daily basis:

- No stress Frequent moderate stress Constant stress
 Occasional mild stress Frequent high stress

Do you drink caffeinated beverages?

- Yes No

Do you drink alcoholic beverages at all?

- Yes No

If yes, please specify:

- 0-2 drinks per week 3-14 drinks per week More than 14 drinks per week

NOTE: One drink per week equals one ounce of hard liquor, 6 oz. of wine, or 12 oz. of beer

MEDICATIONS (Please list any medications you are currently taking and the reason. Include vitamins, supplements, over the counter, prescriptions)

ALLERGIES (Please list:)

Current height: _____ Current weight: _____

The information I have provided in this Waterford Health History Questionnaire is accurate and complete to the best of my knowledge.

Signature: _____ Date: _____