Train Like the Pros.

HEALTH STATUS QUESTIONNAIRE

Complete each question accurately. All information provided is kept confidential.

1. Legal Name _____

2. Mailing Address _____

3. Home Phone _____ Work Phone _____

4. Email Address _____

5. Check Gender: ❑ Female ❑ Male

Height _____ Weight _____

6. Date of Birth _____

7. Physician's Name: _____ Phone: _____

8. Physician's Address: _____

9. Person to contact in case of emergency: _____

10. Check number of hours worked per week:
❑ less than 20 ❑ 21-40 ❑ 41-60 ❑ over 60

11. Check all that apply: More than 25% of time spent on job is:
❑ sitting at desk ❑ lifting/carrying loads ❑ standing/walking ❑ driving

12. Check all who died of heart attack before age 50:
❑ father ❑ mother ❑ brother ❑ sister
❑ grandparent

13. Year of last medical physical exam: _____

14. Year of last fitness test: _____

15. Check operation you have had:
❑ back ❑ heart ❑ kidney ❑ eyes
❑ joint ❑ neck ❑ ears ❑ hernia
❑ lung ❑ other: _____

16. Check any of the following for which you have been diagnosed or treated by a health professional:
❑ anemia ❑ anemia, sickle cell ❑ alcoholism ❑ thyroid problem
❑ neck strain ❑ asthma ❑ back strain ❑ bleeding trait
❑ bronchitis, chronic ❑ obesity ❑ cancer ❑ mental illness
❑ concussion ❑ congenital defect ❑ stroke ❑ diabetes
❑ emphysema ❑ epilepsy ❑ eye problems ❑ gout
❑ ulcer ❑ heart problem ❑ hearing loss ❑ high blood pressure
❑ cirrhosis ❑ phlebitis ❑ hyperlipidemia ❑ hypoglycemia
❑ infectious mononucleosis ❑ kidney problem ❑ rheumatoid arthritis
❑ other: _____

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HEALTH STATUS QUESTIONNAIRE (continued)

17. Check all medicine taken in the last 6 months:

- ❑ blood thinner
- ❑ epilepsy medication
- ❑ nitroglycerin
- ❑ diabetic pill
- ❑ diuretic
- ❑ digitalis
- ❑ heart-rhythm med.
- ❑ insulin
- ❑ high blood-pressure med.
- ❑ Other:

18. Any of these health symptoms that occurs frequently is the basis for medical attention. Fill in the number indicating how often you have each of the following:
3=very often 2=occassionally 1=almost never

a. cough up blood _____ b. abdominal pain _____ c. low back pain _____
d. leg pain _____ e. arm/shoulder pain _____ f. chest pain _____
g. swollen joints _____ h. feel faint/dizzy _____ i. breathlessness _____

19. Do you smoke? ❑ Yes ❑ No

20. If yes, check the number of cigarettes smoked per day:
❑ 40 or more ❑ 20-39 ❑ 10-19 ❑ 1-9

Number of cigars or pipes smoked per day: _____

21. Do you exercise regularly? ❑ Yes ❑ No

22. Number of days per week you spend at least 20 minutes in moderate strenuous exercise:

23. Can you walk 4 miles briskly without fatigue? ❑ Yes ❑ No

24. Can you jog 3 miles continuously at a moderate pace without discomfort?
❑ Yes ❑ No

25. Weight now: _____ One year ago: _____ At age 21: _____

26. List anything not already included on this questionnaire that might cause you problems in a fitness program:

_____

_____

27. I have completed the above to the best of my ability, disclosed all pertinent health information and claim that this document contains the truth.

NAME: _____

DATE: _____

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