Loyola Center for Fitness

Health History Questionnaire

LOYOLA UNIVERSITY CHICAGO 1870 AD MAJOREM DEI GLORIAM | CENTER FOR FITNESS

General Information

Today's Date _____

Member's Full Name _____ Date of Birth _____

Physician's Name _____ Physician's Phone Number _____

Section #1 Check all that apply:

- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Pacemaker/implantable cardiac defibrillator
- ☐ Heart Valve Disease
- ☐ Heart Failure
- ☐ Heart Disease
- ☐ Any other cardiovascular problems not listed on this medical history?
  Please specify:
  _____
  _____
  _____
  _____
- ☐ Diabetes
- ☐ Asthma or lung disease
  Identify:
  _____
- ☐ Currently being treated for cancer
  If so what type:
  _____
- ☐ History of cancer
  If so what type:
  _____
- ☐ Stroke
- ☐ Currently pregnant

Medications

Please list any medications you are currently taking:

_____
_____
_____

Exercise History

On average, **how many days per week** do you exercise or do physical activity?

Days per week: _____

On average, **how many minutes of physical activity** or exercise do you perform each of those days?

Minutes per day: _____

Section #2 Check all that apply:

- ☐ Male ≥ 45 years
- ☐ Female ≥ 55 years, have had a hysterectomy, or are postmenopausal
- ☐ Exercise less than 3 times per week, or get less than a total of 90 minutes per week
- ☐ Current smoker or quit smoking within the previous 6 months or exposure to environmental smoke
- ☐ Have high cholesterol or on medication for (level is ≥ 200 mg/dl)
- ☐ High blood pressure
- ☐ Currently taking medication for blood pressure or heart condition
- ☐ Pain in your chest when you do physical activity
- ☐ Burning cramping sensation in your legs when walking short distances
- ☐ Close blood relative who had a heart attack, heart surgery, or stroke before age 55 (father or brother) or age 65 (mother or sister)?
- ☐ Autoimmune disease
  Please specify:
  _____
- ☐ Vertigo
- ☐ Balance Issues
- ☐ Prone to fainting or seizures (e.g., epilepsy)
- ☐ Brain Injury
  Date:
  _____
- ☐ Osteoporosis/osteopenia
- ☐ Bone or joint problem that could be made worse by a change in your physical activity
  Please specify:
  _____
  _____
- ☐ Concerns about the safety of exercise

Please list any additional comments on your medical history:

_____
_____
_____

Informed Health Risk

This section to be completed with a fitness staff member. Staff initials: _____ Participant signature: _____

☐ Yes, I have been made aware of the above health-risk factors and have been advised to see my physician prior to engaging in activity.

☐ Yes, I have been made aware of my level of health risk: ☐ Low ☐ Moderate ☐ High

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