

Loyola Center for Fitness

Health History Questionnaire



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:

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

_____ | |

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:

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

_____ |
| <input type="checkbox"/> Burning cramping
sensation in your legs
when walking short
distances | <input type="checkbox"/> 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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