ADELPHI UNIVERSITY
Garden City • New York • 11530

SCHOOL OF EDUCATION
ADULT FITNESS PROGRAM
tel. (516) 877-4270
fax (516) 877-4258

Health/Medical Questionnaire

Name: _____ Date: _____
Address: _____ Age: _____ Date of Birth: _____
_____ Sex: _____ Height: _____ Weight: _____
_____ Home Phone: _____
_____ Work Phone: _____

In case of emergency contact Mr/Mrs. _____ phone #: _____

Personal Care Physician: _____
Date of last visit: _____ Reason: _____

1. Have you had or do you have:

□ heart attack	□ thrombophlebitis	□ rapid heart beats
□ angina	□ asthma	□ high blood pressure
□ abnormal electrocardiogram	□ fixed rate pacemaker	□ low blood pressure
□ heart medications	□ embolism	□ high cholesterol
□ valve disease	□ respiratory infections	□ diabetes
□ aneurysm	□ irregular heart beats	□ epilepsy
□ cardiac surgery (ex. bypass, stents)	□ peripheral vascular disease	□ anemia

If yes, please explain _____
_____
_____

2. Has your physician ever advised you against exercise? □ Yes □ No
If yes why and when? _____
_____
_____

3. Do you have any of the following conditions?

□ arthritis	□ ankle/foot injury	□ shoulder/clavicle injur
□ low back pain	□ arm/elbow injury	□ knee/thigh injury
□ calcium deposits	□ nerve damage	□ upper back injury
□ head/neck injury	□ bone fracture	□ wrist/hand injury
□ hip/pelvis injury	□ tennis elbow	

If yes, please explain: _____
_____
_____

Are you presently receiving physical therapy? □ Yes □ No
If yes, Therapist's Name: _____ Phone #: _____
May we call him/her: □ Yes □ No

4. Do you have any conditions or past injuries which limit the range of motion of your muscles, joints, bones, spinal columns or any other part of your body which may be aggravated by exercise? □ Yes □ No
If yes, please explain: _____

5. Are you presently taking any medications on a regular basis? □ Yes □ No
If yes, please list all medications and dosages: _____

Are you allergic to any medications? □ Yes □ No
If yes, please list medications: _____

6. Are you presently under a doctor's care? □ Yes □ No
If yes, why? _____
Dr.'s Name: _____ Phone #: _____
May we call him/her? □ Yes □ No

7. What is your current weight? _____
What was your weight 1 year ago? _____ 5 years ago? _____ At age 20? _____

8. Are you tired or fatigued most of the day? □ Yes □ No
Are you tired or fatigued at a specific time of the day? □ Yes □ No
If yes, when: _____
On average, how much caffeine do you ingest per week? _____
On average, how much alcohol do you drink per week? _____
On average, how many times per year do you travel? _____
On average, how many hours per day do you spend at work? _____days per week? _____

9. How would you rate the amount of physical activity you perform while at work?
□ very little □ moderate □ very active
□ little □ active

How would you rate the amount of physical activity you perform during leisure time?
□ very little □ moderate □ very active
□ little □ active

Are you presently involved in any other Physical Fitness Program □ Yes □ No
If yes, explain: _____

How physically fit do you feel presently?
□ unfit □ average □ very fit
□ below average □ above average

Do you feel that there are any activities which would not interest you or might cause you discomfort or pain? □ Yes □ No
If yes, specify: _____

10. What are your primary reasons for visiting the Adelphi Adult Fitness Program:

11. What is the score of your RISK FACTOR APPRAISAL? _____

I have answered the preceding questions and the RISK FACTOR APPRAISAL to the best of my ability. I have understood all the questions asked of me and have any of my concerns clarified to my satisfaction. I further understand that thorough and honest responses to these questions and the RISK FACTOR APPRAISAL are essential to my safety and prudent recommendations for the Adelphi staff.

Signature: _____ Date: _____

Witness: _____ Date: _____