Health/Medical Questionnaire

Name: ______________________________ Date: ________________

Address: ______________________________ Age: ______ DOB: ____________

______________________________ Sex: ____ Height: ______ Weight: _______

Home Phone: ____________________ Mobile 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
- ☐ angina
- ☐ abnormal electrocardiogram
- ☐ heart medications
- ☐ valve disease
- ☐ aneurysm
- ☐ cardiac surgery (ie. bypass, stents)
- ☐ thrombophlebitis
- ☐ asthma
- ☐ pulmonary disease
- ☐ embolism
- ☐ pacemaker
- ☐ irregular heartbeats
- ☐ peripheral vascular disease
- ☐ rapid heart beats
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ high cholesterol
- ☐ diabetes
- ☐ epilepsy
- ☐ anemia

If yes, please explain ____

____

2. Has your physician ever advised you against exercise? ☐ Yes ☐ NO
If yes, please explain: ____

____

3. Do you have any of the following conditions?

- ☐ arthritis
- ☐ back pain
- ☐ nerve damage
- ☐ head/neck injury
- ☐ lower extremity injury
- ☐ hip/pelvis injury
- ☐ upper back injury
- ☐ bone fracture

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, back/neck 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: attach separate sheet.

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? _______

8. Are you tired or fatigued during the day? ☐ Yes ☐ No

If yes, when ______________________________
On average, how much caffeine do you ingest per week? ____________
how much alcohol do you drink per week? ____________
how many times per year do you travel? ____________
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?

☐ minimal ☐ moderate ☐ active

How would you rate the amount of physical activity you perform during leisure time?

☐ I am mostly sedentary ☐ moderate ☐ I am active most days of the week

Are you presently involved in any other Physical Fitness Program? ☐ Yes ☐ No

If yes, explain: ______________________________

How physically fit do you feel presently? ☐ I feel very unfit

☐ I am winded climbing stairs ☐ I can do my household chores without undue fatigue

☐ I can walk 1-3 miles comfortably ☐ I can jog/run 1-3 miles comfortably

Do you experience discomfort or painwhile performing any physical tasks? ☐ Yes ☐ No

If yes, specify: ______________________________

____

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

____

____

____

I have answered the preceding questions to the best of my ability. I understand that information gathered from this questionnaire is essential for the Adelphi staff to develop a safe and effective exercise program for me.

Signature: ______________________________ Date: _____________

AFP Staff review: ______________________________ Date: _____________