Medical Health History

All information given is personal and confidential. The information will enable us to better understand you and your health and fitness habits.

Name: _____ GT ID: _____ Date: _____
Date of Birth: _____/_____/_____ Gender: _____ Height: _____ Weight: _____
Address: _____ City, State: _____
Zip Code: _____ Home Phone: _____ Business Phone:_____
Email: _____ Occupation: _____

I. Signs and Symptoms

Have you ever experienced any of the following: (please check yes or no)

YES	NO	
☐	☐	1. Pain, discomfort, tightness or numbness in the chest, neck, jaw or arms.
☐	☐	2. Shortness of breath at rest or with mild exertion.
☐	☐	3. Dizziness or fainting.
☐	☐	4. Difficult, labored or painful breathing during the day or at night.
☐	☐	5. Ankle swelling.
☐	☐	6. Rapid pulse or heart rate.
☐	☐	7. Intermittent cramping.
☐	☐	8. Known heart murmur.
☐	☐	9. Unusual shortness of breath or fatigue with usual activities.

If you answered yes to any of the above:

How often do you experience the symptom?
_____

Have you ever discussed the symptom with a doctor?
_____

Explain the symptom in more detail:
_____

_____

_____

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II. Major Risk Factors

YES	NO	
☐	☐	1. Do you have a body mass index ≥ 30 or a waist girth >100 cm (39.3 inches)?
☐	☐	2. Have you had a fasting glucose of ≥ 110 mg/dl confirmed by measurements on at least 2 separate occasions.
☐	☐	3. Has your father or brother experienced a heart attack before the age of 55? Or has your mother or sister experienced a heart attack before the age of 65?
☐	☐	4. Do you currently smoke or quit within the past 6 months?
☐	☐	5. Has your doctor ever told you that you have high blood pressure?
☐	☐	6. Do you have high cholesterol? Total cholesterol: _____ HDL:_____ LDL: _____ Date tested: _____
☐	☐	7. Do you have a sedentary lifestyle? (sitting most of the day in your job with no regular physical activity)

III. Medical Diagnoses

Have you ever experienced any of the following? Please circle all that apply:

Anemia	Cancer	Emphysema	Osteoporosis
Angina	Coronary Artery Disease	Heart Attack	Phlebitis
Angioplasty	Diabetes	Heart Murmur	Pregnancy
Arthritis	Eating Disorders	Heart Surgery	Stroke
Asthma	Emotional Disorders	Hernia	
Bronchitis	Emoboli	Hypertension	

Any special problems not listed above: _____

If any of the above are circled, please give details and explain: _____

_____

_____

_____

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IV. General

YES	NO	
☐	☐	1. Are you pregnant?
☐	☐	2. Do you have arthritis or any bone or joint problem? If yes, please explain: _____ _____
☐	☐	3. Do you currently exercise? If yes, how long have you been exercising? _____ If yes, how often do you exercise? _____ What type of exercise activities do you do? _____
☐	☐	4. Are you taking any medication, vitamins or supplements? Drug name/dosage/purpose of drug/ prescribed or over-the-counter _____ _____ _____

My signature certifies that all of the above is true, to the best of my knowledge.

Signature: _____ Date: _____

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STAFF USE ONLY

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Comments:

_____

_____

_____

Stratification (circle one): Low Risk Moderate Risk High Risk

Resting Blood Pressure: _____ Resting heart rate: _____ bpm

Do meds affect BP or HR? Yes No

Date: _____ Trainer Initials: _____

Client Name: _____ Date: _____

Campus Recreation

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