Medical History and Screening Form

General Information

Participant

Name _____

Address _____

Contact phone numbers _____

Birthdate _____

Family Physician and/or Primary Health Care Provider

Doctor/other _____ Phone _____

Address _____ City _____

May I send a copy of your consultation to your physician or primary health care provider? ❑ Yes ❑ No

Marital Status

❑ Single ❑ Married ❑ Divorced ❑ Widowed

Sex

❑ Male ❑ Female

Education

❑ Grade School ❑ Jr. High School ❑ High School ❑ College (2-4 years)

❑ Graduate School ❑ Degree _____

Occupation

Position _____ Employer_____

Address _____

Phone _____

What is (are) your purpose(s) for participation in this fitness program?

❑ To determine my current level of physical fitness and to receive recommendations for an exercise program.

❑ Other (please explain) _____

_____

_____

_____

Present Medical History

Check those questions to which your answer is yes (leave the others blank).

- ❑ Has a doctor ever said your blood pressure was too high?
- ❑ Do you ever have pain in your chest or heart?
- ❑ Are you often bothered by a thumping of the heart?
- ❑ Does your heart often race like mad?
- ❑ Do you ever notice extra heartbeats or skipped beats?
- ❑ Are your ankles often badly swollen?
- ❑ Do cold hands or feet trouble you even in hot weather?
- ❑ Has a doctor ever said that you have or had heart trouble, an abnormal electrocardiogram (ECG or EKG), heart attack, or coronary?
- ❑ Do you suffer from frequent cramps in your legs?
- ❑ Do you often have difficulty breathing?
- ❑ Do you get out of breath long before anyone else?
- ❑ Do you sometimes get out of breath when sitting still or sleeping?
- ❑ Has a doctor ever told you your cholesterol level was high?

Comments: _____

Do you now have or have you recently experienced:

- ❑ Chronic, recurrent, or morning cough?
- ❑ Episode of coughing up blood?
- ❑ Increased anxiety or depression?
- ❑ Problems with recurrent fatigue, trouble sleeping, or increased irritability?
- ❑ Migraine or recurrent headaches?
- ❑ Swollen or painful knees or ankles?
- ❑ Swollen, stiff, or painful joints?
- ❑ Pain in your legs after walking short distances?
- ❑ Foot problems?
- ❑ Back problems?
- ❑ Stomach or intestinal problems, such as recurrent heartburn, ulcers, constipation, or diarrhea?
- ❑ Significant vision or hearing problems?
- ❑ Recent change in a wart or a mole?
- ❑ Glaucoma or increased pressure in the eyes?
- ❑ Exposure to loud noises for long periods?

Comments: _____

Family Medical History

Father:

❑ Alive Current age _____

My father's general health is:

❑ Excellent ❑ Good ❑ Fair ❑ Poor

Reason for poor health:

❑ Deceased Age at death _____

Cause of death: _____

Mother:

❑ Alive Current age _____

My mother's general health is:

❑ Excellent ❑ Good ❑ Fair ❑ Poor

Reason for poor health:

❑ Deceased Age at death _____

Cause of death: _____

Familial Diseases

Have you or your blood relatives had any of the following? (Include grandparents, aunts and uncles, but exclude cousins, relatives by marriage and half-relatives.)

Check those to which the answer is yes (leave others blank).

❑ Heart attacks under age 50
❑ Strokes under age 50
❑ High blood pressure
❑ Elevated cholesterol
❑ Diabetes
❑ Asthma or hay fever
❑ Congenital heart disease (existing at birth but not hereditary)
❑ Heart operations
❑ Glaucoma
❑ Obesity (20 or more pounds overweight)
❑ Leukemia or cancer under age 60

Comments: _____

Other Heart Disease Risk Factors

Smoking

Have you ever smoked cigarettes, cigars, or a pipe?

❑ Yes ❑ No

(If no, skip to Diet section)

If you did or now smoke cigarettes, how many per day? _____ Age started _____

If you did or now smoke cigars, how many per day? _____ Age started _____

If you did or now smoke a pipe, how many pipefuls a day? _____ Age started _____

If you have stopped smoking, when was it? _____

If you now smoke, how long ago did you start? _____

Diet

What do you consider a good weight for yourself? _____

What is the most you ever weighed (including when pregnant)? _____

How old were you? _____

My current weight is: _____

One year ago my weight was: _____

At age 21 my weight was: _____

Number of meals you usually eat per day: _____

Average number of eggs you eat per week: _____

Number of times per week you usually eat the following:

Beef _____ Fish _____ Desserts _____

Pork _____ Fowl _____ Fried foods _____

Number of servings (cups, glasses, or containers) per week you usually consume of:

Homogenized (whole) milk _____ Buttermilk _____ Skim (nonfat) milk _____

2% (low-fat) milk _____ 1% (low-fat) milk _____ Coffee _____

Tea (iced or hot) _____ Regular or diet sodas _____ Glasses of water _____

Past Medical History

Check those questions to which your answer is yes (leave the others blank).

❑ Heart attack If so, how many years ago? _____

❑ Rheumatic fever

❑ Heart murmur

❑ Diseases of the arteries

❑ Varicose veins

❑ Arthritis of legs or arms

❑ Diabetes or abnormal blood-sugar tests

❑ Phlebitis (inflammation of a vein)

❑ Dizziness or fainting spells

❑ Epilepsy or seizures

❑ Stroke

❑ Diphtheria

❑ Scarlet fever

❑ Infectious mononucleosis

❑ Nervous or emotional problems

❑ Anemia

❑ Thyroid problems

❑ Pneumonia

❑ Bronchitis

❑ Asthma

❑ Abnormal chest X-ray

❑ Other lung disease

❑ Injuries to back, arms, legs, or joints

❑ Broken bones

❑ Jaundice or gall bladder problems

Comments: _____

Women only answer the following. Do you have:

❑ Menstrual period problems?

❑ Significant childbirth-related problems?

❑ Urine loss when you cough, sneeze, or laugh?

Date of last pelvic exam and/or Pap smear _____

Comments: _____

Are you on any type of hormone replacement therapy?

Men and women answer the following:

List any prescription medications you are now taking: _____

List self-prescribed medications or dietary supplements you are now taking: _____

Date of last complete physical examination: _____

❑ Normal ❑ Abnormal ❑ Never ❑ Can't remember

Date of last chest X-ray: _____

❑ Normal ❑ Abnormal ❑ Never ❑ Can't remember

Date of last electrocardiogram (EKG or ECG): _____

❑ Normal ❑ Abnormal ❑ Never ❑ Can't remember

Date of last dental checkup: _____

❑ Normal ❑ Abnormal ❑ Never ❑ Can't remember

List any other medical or diagnostic test you have had in the past two years: _____

List hospitalizations, including dates of and reasons for hospitalization: _____

List any drug allergies: _____