



FitWell
HEALTH HISTORY QUESTIONNAIRE

NAME _____ DATE _____ DOB _____
First M.I. Last day/month/yr

ADDRESS _____
Street City State Zip

TELEPHONE# _____ EMAIL ADDRESS _____

OCCUPATION _____ AGE _____ SEX _____

Have you previously been tested for an exercise program? YES ___ NO ___ YEAR (s) _____

Location of test _____

Person to contact in case of emergency _____ Phone # _____

Relationship _____

PLEASE CHECK YES OR NO

PAST HISTORY

(Have you ever had?) YES NO

- High blood pressure
Any heart trouble
Disease of the arteries
Varicose veins
Lung disease
Asthma
Kidney disease
Hepatitis

FAMILY HISTORY

(have any immediate family YES NO or grandparents had?)

- Heart attacks
High blood pressure
High cholesterol
Stroke
Diabetes
Congenital heart defect
Heart operations
Early death
Other family illnesss

PRESENT SYMPTOMS

(have you recently had?) YES NO

- Chest pain/discomfort
Shortness of breath
Heart palpations
Skipped heart beats
Cough on exertion
Dizzy spells
Frequent headaches
Frequent colds
Back pain
Orthopedic problems

NOTES: _____

HOSPITALIZATIONS: Please list recent hospitalizations (Women: omit normal pregnancies)

Table with 3 columns: Year, Location, Reason

Any other medical problems/concerns not already identified?

Have you every had your cholesterol measured? Yes ___ No ___; If yes, (value) _____
(Date) _____ Where? _____

Are you taking any Prescription or Non-Prescription medications? Yes ___ No ___
(include birth control)

Medication	Reason for Taking	For How Long?
_____	_____	_____
_____	_____	_____

Do you currently smoke? Yes ___ No ___ If so, what? Cigarettes ___ Cigars ___ Pipe ___
How much per day: <.5 pack _ 0.5 to 1 pack _____ 1.5 to 2 packs _____ >2 packs _____

Have you ever quit smoking? Yes ___ No ___ When? _____ How many years and how much did you smoke? _____

Do you drink any alcoholic beverages? Yes ___ No ___ If Yes, how much in 1 week?

Beer _____ (cans) Wine _____ (glasses) Hard liquor _____ (drinks?)

Do you drink any caffeinated beverages? Yes _____ No ___ If Yes, how much in 1 week?

Coffee _____ (cups) Tea _____ (glasses) Soft drinks _____ (cans)

ACTIVITY LEVEL:	STRESSES AFFECTING YOUR LIFE:
<input type="checkbox"/> Sedentary (inactive) by choice	<input type="checkbox"/> Difficulties with work or lifestyle
<input type="checkbox"/> Sedentary (inactive) due to inability or restriction	<input type="checkbox"/> Recent change in marital status
<input type="checkbox"/> Light: light daily work w/no regular exercise	<input type="checkbox"/> Death or serious illness of family or friend
<input type="checkbox"/> Moderate: light daily work and exercise 3X/week	<input type="checkbox"/> Dysfunctional family ___ Past ___ Present
<input type="checkbox"/> Sustained: moderate daily work & exercise 5X/week	<input type="checkbox"/> Lack of love or fulfilling relationship(s)
<input type="checkbox"/> Sustained: moderate daily work & exercise 5X/week	<input type="checkbox"/> Illness – self

Please use the space below to indicate any other issues/injuries the technician should know of:

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