Health History Questionnaire

Wellness Works Health and Fitness Center
A service of Washington County Regional Medical Center

Name (please print) _____

Home Address _____
(Street or P.O.) (City) (State)
E-Mail _____

Telephone (h) _____ (w) _____(c) _____

Height _____ Weight _____

Gender _____ Birth date _____ Age _____

Regular physical activity is safe for most people. However, some individuals should check with their doctor before they start an exercise program. To help us determine if you should consult with your doctor before starting to exercise with Wellness Works, please read the following questions carefully and answer each one honestly. All information will be kept confidential. Access your health by marking all TRUE statements:

History
You have had:
_____ a heart attack
_____ heart surgery
_____ stent
_____ cardiac catheterization
_____ coronary angioplasty (PTCA)
_____ pacemaker/implantable cardiac
_____ defibrillator/rhythm disturbance
_____ heart valve disease
_____ heart failure
_____ heart transplantation
_____ congenital heart disease

Prevention
You have had:
_____ colonoscopy
_____ mammography
_____ PSA
_____ bone density
_____ physical
_____ pap smear

Symptoms
_____ You experience chest discomfort with exertion.
_____ You experience unreasonable breathlessness.
_____ You experience dizziness, fainting or blackouts.
_____ You take heart medications.

Other health issues
_____ You have diabetes or your fasting glucose level is higher than normal (prediabetes).
_____ You have asthma or other lung disease.
_____ You have burning or cramping sensation in your lower legs when walking short distances.
_____ You have musculoskeletal problems that limit your physical activity.
_____ You have concerns about the safety of exercise.
_____ You take prescription medication(s).
_____ You are pregnant.

Cardiovascular risk factors
_____ You are a man older than 45 years.
_____ You are a woman older than 55 years, have had a hysterectomy, or are postmenopausal.
_____ You smoke, or quit smoking within the previous 6 months.
_____ You are exposed to environmental tobacco smoke.
_____ Your blood pressure is >140/90 mm hg.
_____ You do not know your blood pressure.
_____ You take blood pressure medication.
_____ Your blood cholesterol level is >200 mg/dl.
_____ You do not know your cholesterol level.
_____ You have a close blood relative who had a heart attack or heart surgery before age 55 (father or brother) or age 65 (mother or sister).
_____ You are physically inactive (i.e. you get < 30 minutes of physical activity on at least 3 days per week for at least 3 months).
_____ You are > 20 pounds overweight.

_____ **None of the Above**

Continued on back…….

Please list all medication(s) and its purpose: _____

_____

_____

Please list any operations you have had: _____

_____

Have you been diagnosed with any conditions not listed (if answer is yes, please list) YES NO

_____

_____

I have read, understood, and completed this questionnaire. Any questions that I have were answered to my full satisfaction.

Name_____ Date _____

Signature _____

STAFF USE ONLY

Cleared to exercise _____ Not Cleared to exercise _____

Reason _____

Physicians Statement and Clearance Form sent _____

Staff Signature _____ Date _____

Resting Heart Rate _____

Resting Blood Pressure _____

Weight _____

Initiated: 04/96
Revised: 10/05,03/07, 06/10