Medical History Questionnaire

Demographic Information

Last name	First name	Middle initial
Date of birth	Sex	Home phone
Address	City, State	Zip code
Work phone	Family physician	

Section A

1. When was the last time you had a physical examination?
2. If you are allergic to any medications, foods, or other substances, please name them.
3. If you have been told that you have any chronic or serious illnesses, please list them.
4. Give the following information pertaining to the last 3 times you have been hospitalized. *Note:* Women, do not list normal pregnancies.

	Hospitalization 1	**Hospitalization 2**	**Hospitalization 3**
Reason for hospitalization			
Month and year of hospitalization			
Hospital			
City and state			

Section B

During the past 12 months

1. Has a physician prescribed any form of medication for you? ❒ Yes ❒ No
2. Has your weight fluctuated more than a few pounds? ❒ Yes ❒ No
3. Did you attempt to bring about this weight change through diet or exercise? ❒ Yes ❒ No
4. Have you experienced any faintness, light-headedness, or blackouts? ❒ Yes ❒ No
5. Have you occasionally had trouble sleeping? ❒ Yes ❒ No
6. Have you experienced any blurred vision? ❒ Yes ❒ No
7. Have you had any severe headaches? ❒ Yes ❒ No
8. Have you experienced chronic morning cough? ❒ Yes ❒ No
9. Have you experienced any temporary change in your speech pattern, such as slurring or loss of speech? ❒ Yes ❒ No
10. Have you felt unusually nervous or anxious for no apparent reason? ❒ Yes ❒ No
11. Have you experienced unusual heartbeats such as skipped beats or palpitations? ❒ Yes ❒ No
12. Have you experienced periods in which your heart felt as though it were racing for no apparent reason? ❒ Yes ❒ No

From *Advanced Fitness Assessment and Exercise Prescription, Sixth Edition,* by Vivian H. Heyward, 2010, Champaign, IL: Human Kinetics.

At present

1. Do you experience shortness or loss of breath while walking with others your own age? ❒ Yes ❒ No
2. Do you experience sudden tingling, numbness, or loss of feeling in your arms, hands, legs, feet, or face? ❒ Yes ❒ No
3. Have you ever noticed that your hands or feet sometimes feel cooler than other parts of your body? ❒ Yes ❒ No
4. Do you experience swelling of your feet and ankles? ❒ Yes ❒ No
5. Do you get pains or cramps in your legs? ❒ Yes ❒ No
6. Do you experience any pain or discomfort in your chest? ❒ Yes ❒ No
7. Do you experience any pressure or heaviness in your chest? ❒ Yes ❒ No
8. Have you ever been told that your blood pressure was abnormal? ❒ Yes ❒ No
9. Have you ever been told that your serum cholesterol or triglyceride level was high? ❒ Yes ❒ No
10. Do you have diabetes? ❒ Yes ❒ No

    If yes, how is it controlled?

    ❒ Dietary means ❒ Insulin injection
    ❒ Oral medication ❒ Uncontrolled
11. How often would you characterize your stress level as being high?

    ❒ Occasionally ❒ Frequently ❒ Constantly
12. Have you ever been told that you have any of the following illnesses? ❒ Yes ❒ No

    ❒ Myocardial infarction ❒ Arteriosclerosis ❒ Heart disease ❒ Thyroid disease
    ❒ Coronary thrombosis ❒ Rheumatic heart ❒ Heart attack ❒ Heart valve disease
    ❒ Coronary occlusion ❒ Heart failure ❒ Heart murmer
    ❒ Heart block ❒ Aneurysm ❒ Angina
13. Have you ever had any of the following medical procedures? ❒ Yes ❒ No

    ❒ Heart surgery ❒ Pacemaker implant
    ❒ Cardiac catheterization ❒ Defibrilator
    ❒ Coronary angioplasty ❒ Heart transplantation

Section C

Has any member of your immediate family been treated for or suspected to have had any of these conditions? Please identify their relationship to you (father, mother, sister, brother, etc.).

A. Diabetes

B. Heart disease

C. Stroke

D. High blood pressure

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