HEALTH HISTORY QUESTIONAIRE

Directions: In order to devise a safe and effective wellness program for you, we ask that you complete this form carefully. All information will be treated as strictly ***CONFIDENTIAL***.

1. PERSONAL INFORMATION

Name: Last	First	Middle Initial	Date of Birth	Sex
Address		City/State	Zip Code	
Email		Home Phone	Cell Phone	
Occupation		Place of Employment		Work Phone
Family Physician	Emergency Contact Person		Emergency Contact Phone	

When was your last physical?

Please list any serious or chronic illness that you are aware of:

Please list any allergies to medications, foods or other substances:

Please list any medications you are presently taking in the chart below:

Name of Medication	Dosage and Frequency	How Long	Reason

2. MEDICAL HISTORY

Please check if you have had any of the following:

Illness	Present	Past	Dates	Illness	Present	Past	Dates
Heart Attack				Gout			
Anemia				Diabetes			
Asthma				Hypoglycemia			
Epilepsy/Convulsions				Rheumatic Fever			
Back/Disc Problems				Heart Murmur			
Lung Disease				Hernia			
Stroke				Cancer			

If yes, how is the illness controlled?

Symptoms: *During the last 12 months have you experienced:*

High Blood Pressure	Yes	No	Shortness of breath	Yes	No
Swelling of hands and feet	Yes	No	Numbness/tingling in arms, legs or face	Yes	No
Pain or cramps in legs	Yes	No	Unusual fatigue or dizziness	Yes	No
ECG Abnormalities	Yes	No	Significant weight fluctuation	Yes	No
Blurred Vision	Yes	No	High Triglycerides	Yes	No
Skipped beats/palpitations	Yes	No	High Cholesterol	Yes	No
Chest pain or pressure	Yes	No			

3. FAMILY HISTORY

Have your father, mother, grandparents, or siblings had:

High Blood Pressure	No	Yes	Who:
Stroke	No	Yes	Who:
Heart Attack (50-)	No	Yes	Who:
Heart Attack (50+)	No	Yes	Who:
Diabetes	No	Yes	Who:

4. HEALTH HABITS HISTORY

Smoking

- Do you currently smoke? Yes No If yes, how many packs per day? _____
- Did you ever smoke? Yes No If yes, how many packs per day? _____
- If you have stopped smoking, what was the approximate date? _____
- Do you smoke cigars or a pipe? Yes No If yes, how many per day? _____

Tension / Anxiety

- How would you describe your tension most of the time? (circle one)

No Tension, very relaxed Slight Tension Moderate Tension

High Tension Very Tense "High Strong"

- Do you practice any relaxation skills to eliminate tension? Yes No
  If yes, what do you practice?

_____

Physical Activity

- Are you currently involved in any physical activity? Yes No If yes, please list activities:

_____

- How many times do you exercise per week? _____
- Do you consider yourself to be in better physical condition than others your age? Yes No

5. MUSCULOSKETAL HISTORY

Do you have any injuries (past or present) or limitations that may affect full participation in an exercise program (ie. arthritis, bursitis, disc problems, lower back pain, Achilles tendon, knee ligament/cartilage problems, joint replacements, etc.) Yes No If yes, please list: