HEALTH AND LIFESTYLE HISTORY QUESTIONNAIRE

Name: _____Date: _____

Address: _____Phone: (Home)_____

City: _____State: _____Phone: (Cell)_____

Zip Code_____ Phone: (Work) _____

Birth Date: _____/_____/_____ Age: _____ Sex: _____ E-mail_____

Physician's Name: _____ Physician's Phone: _____

1. Has a doctor ever told you that you have, or have you experienced any of the following?

_____ Heart disease	_____ Hernia	_____ Emphysema
_____ Skipped heartbeats	_____ High blood pressure	_____ Asthma
_____ Irregular heartbeats	_____ High cholesterol	_____ Bronchitis
_____ Angina	_____ Cancer	_____ Arthritis
_____ Heart valve problems	_____ Epilepsy	_____ Bursitis
_____ Heart attack	_____ Stroke	_____ Diabetes
_____ Heart murmurs		

Please explain/other: _____

_____

2. Are you experiencing any of the following?

_____ Back pain	_____ Shortness of breath	_____ Light-headedness
_____ Joint or muscular pain	_____ Anxiety	_____ Depression
_____ Chest pain	_____ Fatigue	_____ Insomnia
_____ Ankle swelling	_____ Frequent urination	_____ Migraine headaches

Please explain/other: _____

_____

3. Please list any medications or dietary supplements you are currently taking (name and reason).

_____ _____

_____ _____

_____ _____

_____ _____

4. Has anyone in your immediate family (father, mother, brother, sister, or children) had any of the following?

_____ Heart attack	_____ High cholesterol	_____ Diabetes
_____ Congenital heart disease	_____ Stroke	_____ Early death
_____ Heart operations		

Please explain/other: _____

_____

5. Have you ever had any medical conditions for which a doctor has recommended restrictions on physical activity (including surgery)?
_____ No _____ Yes

Please explain/other: _____

_____

6. If female, are you pregnant?
_____ No _____ Yes

7. Do you smoke?
_____ No _____ Yes If yes, how long?: _____ How much?:_____

8. Do you drink alcoholic beverages at all?
_____ No _____ Yes
_____ 0-4 drinks per week
_____ 5-14 drinks per week
_____ 14+ drinks per week

9. Do you drink coffee or colas with caffeine?
_____ No _____ Yes If yes, amount per day: _____

10. Do you usually eat breakfast?
_____ No _____ Yes

11. Have you had your cholesterol measured within the past year?
_____ No _____ Yes

If yes, results: _____

12. How would you classify your occupation?
_____ Active _____ Sedentary Occupation: _____

13. Check the description that best represents the amount of stress you experience on a daily basis.
_____ No stress _____ Occasional mild stress _____ Frequent moderate stress
_____ Frequent high stress _____ Constant high stress

14. Are you presently exercising a minimum of 2 times per week for at least 30 minutes at a time?
_____ No _____ Yes

If yes, please specify:
_____ Running/jogging _____ Racket sports _____ Weight training
_____ Walking _____ Water sports _____ Aerobic dance
_____ Biking _____ Swimming

Please explain/other: _____

_____

15. How would you rate your level of fitness at this time? Example : Excellent, Good, Fair, Poor

_____