Health History Questionnaire

Name:_____ Age:_____ Date of birth:_____
First M.I Last month / day / yr

Address:_____
street city state zip

Telephone (home): _____ (cel):_____
Occupation:_____ Place of Employment:_____
Marital Status:(circle one) SINGLE MARRIED DIVORCED WIDOWED SPOUSE:_____

Personal Physician:_____ Location:_____
Physicians Number:_____
Reason for last doctor visit?_____Date of last physical exam?_____
What is your current weight?_____ Height?_____
Have you previously been tested for an exercise program? YES___ NO___ YEAR(s)_____
Location of test:_____
Person to contact in case of an emergency:_____
Phone#_____ (relationship):_____

PLEASE CHECK YES OR NO

PAST HISTORY			FAMILY HISTORY			PRESENT SYMPTOMS		
(Have you ever had?)	YES	NO	(Have any immediate family or grandparents had?)	YES	NO	(Have you recently had?)	YES	NO
High blood pressure	☐	☐	Heart attacks	☐	☐	Chest pain/ discomfort	☐	☐
Any heart trouble	☐	☐	High blood pressure	☐	☐	Shortness of breath	☐	☐
Disease of the arteries	☐	☐	High cholesterol	☐	☐	Heart palpitations	☐	☐
Varicose veins	☐	☐	Stroke	☐	☐	Skipped heart beat	☐	☐
Lung disease	☐	☐	Diabetes	☐	☐	Cough on exertion	☐	☐
Asthma	☐	☐	Congenital heart defect	☐	☐	Coughing of blood	☐	☐
Kidney disease	☐	☐	Heart operations	☐	☐	Dizzy spells	☐	☐
Hepatitis	☐	☐	Early death	☐	☐	Frequent headaches	☐	☐
Diabetes	☐	☐	Other family illness	☐	☐	Frequent colds	☐	☐
Heart murmur	☐	☐	_____			Back pain	☐	☐
Arthritis	☐	☐	_____			Orthopedic problems	☐	☐

(For staff)

_____

_____

Hospitalizations: Please list recent hospitalizations (Women: do not list normal pregnancies)
year location reasons

_____
_____
_____

Any other medical problems/ concerns not already identified? Yes___No___(Please list below)_____
_____

Have you ever 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 pills)
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_____ >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 EVALUATION
What is your occupational activity level? Sedentary___ Light___ Moderate___ Heavy___

Do you currently engage in vigorous physical activity on a regular basis? Yes____ No_____
If so, what type_____How many days per week?_____
How much time per day? (check one) <15min____ 15-30min____ 30-45min____ >60min____
Do you ever have uncomfortable shortness of breath during exercise? Yes____ No____
Do you ever have chest discomfort during exercise? Yes_____ No_____
If so, does it go away with rest?_____

Do you engage in any recreational or leisure-time physical activities on a regular basis?
Yes_____ No_____
If so, what activities?_____
On average: How often?_____times/week; For how long?_____time/session

Are you currently following a weight reduction diet plan? Yes____ No____
If so, how long have you been dieting? _____months
Is the plan prescribed by your doctor? Yes_____ No_____

Have you used weigh reduction diets in the past? Yes_____No_____; If yes, how often and what type?_____

Please list everything you eat in one 24 hr period. Include any snacks and beverages including water intake. Be as specific as possible.

Time:	Food/ Beverage:
Time:	Food/ Beverage:
Time:	Food/ Beverage:
Time:	Food/ Beverage:
Time:	Food/ Beverage:
Time:	Food/ Beverage:
Time:	Food/ Beverage:
Time:	Food/ Beverage:

Make a list of your favorite healthy foods:

1.
2.
3.
4.
5.

Make a list of your least favorite healthy foods:

1.
2.
3.
4.
5.

Have you ever been placed on a specific nutritional program before? Yes_____ No_____

If so, who created it for you and what did it consist of?

_____
_____
_____

What were your results?

_____
_____
_____

I, _____, agree to allow the trainers at San Pedro Fit to design a fitness program for me to enhance my health and fitness goals. I will follow that program to the best of my ability and I will not hold San Pedro Fit or any of their staff personally liable for any problems, injuries or illnesses that might occur due to a sudden change in my current behavior. This weight management program does not replace the expert advice or medical treatment of my own private doctor. I have given San Pedro Fit all necessary information about myself to prevent any possible complications.

Signature:_____ Date:_____