Health History Questionnaire for Wellness/Fitness Program

All of your responses are completely confidential. Group summaries or activity reports have individual identifiers removed. All information collected is subject to the Privacy Act of 1974. **If you require special assistance with the questionnaire or with arranging fitness appointments or services, please call _____ for further assistance.**

ALL INFORMATION MUST BE COMPLETED!

Name: _____ **Gender:** _____

Age _____ **Birth Date:** ____/ 01/____ *(record only month/year)*

Office Address: _____ **Room #:** _____

Office Phone: _____ **Ext:** _____

E-mail address: _____

Federal Agency: _____ **Division:** _____

Personal Physician: _____ **Phone:** _____

Address: _____ **Fax:** _____

City: _____ **State:** _____ **Zip:** _____

Emergency Contact: _____ **Phone:** _____

MANDATORY FIELD
For completion by FOH Staff

	INITIAL	ANNUAL	PERIODIC
Cholesterol (≥200)			_____
HDL (<40)			_____
LDL (≥ 130)			_____
Glucose (≥100)			_____
Blood Pressure			_____
Height (in.)			_____
Weight			_____
BMI (kg/m^2)			_____
Waist girth (cm.)			_____

Risk Stratification ☐L ☐M ☐H

Medical Clearance ☐Y ☐N

Next Restrat _____/_____ (Mo. / Yr.)

Information regarding your health history, including genetic information, is being collected as part of a voluntary health and fitness program. The Genetic Information Nondiscrimination Act of 2008 (GINA) limits how employers may use such genetic information and prohibits disclosure of genetic information, except as specifically allowed by this law. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, whether an individual or an individual's family member has sought genetic services, and genetic information of a fetus or embryo of an individual or an individual's family member. The information requested will be used solely to assess your risk of certain diseases and to provide advice on how to prevent them. Information will be kept confidential and not disclosed to your employer except when required by law.

1. Have you ever had any of the following? (Please check all that apply) ..... ☐ Yes ☐ No

- ☐ Heart attack, failure or surgery
- ☐ Pacemaker or defibrillator
- ☐ Diabetes
- ☐ Catheterization or angioplasty
- ☐ Heart murmur or valve disease
- ☐ Thyroid disorder
- ☐ Congenital heart disease
- ☐ Asthma, COPD, lung disease
- ☐ Kidney or liver disease

2. Do you have any of the following? (Please check all that apply) ..... ☐ Yes ☐ No

- ☐ Cancer
- ☐ Musculoskeletal problems
- ☐ Current pregnancy (due date _____)
- ☐ Back pain
- ☐ Blood clots
- ☐ Arthritis
- ☐ Exercise safety concerns
- ☐ Osteoporosis
- ☐ Recent surgery

3. Has a doctor ever told you that you should not exercise? ☐ Yes ☐ No

4. If you answered yes to any of Questions 1 to 3, please describe:

_____

_____

5. Have you experienced any of the following within the past 12 months***:

a. Pain or discomfort in the chest, neck, jaw, or arms at rest or during physical activity ..... ☐ Yes ☐ No
b. Shortness of breath or wheezing at rest or with mild exertion ..... ☐ Yes ☐ No
c. Dizziness, fainting or blackouts. ..... ☐ Yes ☐ No
d. Difficulty breathing at night, except in upright position ..... ☐ Yes ☐ No
e. Swelling of the ankles (recurrent and unrelated to injury) ..... ☐ Yes ☐ No
f. Heart palpitations (irregularity or racing of the heart on more than one occasion) ..... ☐ Yes ☐ No
g. Burning or cramping in the legs when you walk short distances ..... ☐ Yes ☐ No
h. Unusual fatigue or shortness of breath with usual activities ..... ☐ Yes ☐ No

*** If yes, please describe: _____

*** Have you discussed any of the above with your personal physician? ..... ☐ Yes ☐ No

6. Are you a male 45 years of age or older? ..... ☐ Yes ☐ No

7. Are you a female 55 years of age or older, have had a hysterectomy or are post menopausal? ..... ☐ Yes ☐ No

8. * Have either your father or brother prior to age 55 and/or mother or sister prior to age 65 had heart disease, a heart attack, or stroke? ..... ☐ Yes ☐ No

9. Do you currently smoke cigarettes or have you quit within the last 6 months or have you been exposed to environmental tobacco smoke? ..... ☐ Yes ☐ No

10. Do you engage in moderate physical activity for at least 30 minutes a day on three days a week? ... ☐ Yes ☐ No

11. Has your doctor ever told you that you need to lose weight? ..... ☐ Yes ☐ No

12. Has your doctor ever told you that you have high blood pressure or are you on medicine to control your blood pressure? ..... ☐ Yes ☐ No

13. Has your blood glucose level ever been high or has a doctor ever told you that you have prediabetes? ☐ Yes ☐ No

14. Has your doctor ever told you that your cholesterol is high? ..... ☐ Yes ☐ No

15. Please list all prescription and over-the-counter medications you have been prescribed.

Medicine:	Reason for taking:	Dosage:	Amount/Frequency:

16. Are there any medicines that your physician has prescribed to you in the past 12 months which you are currently not taking? (please note above under frequency) ..... ☐ Yes ☐ No

If yes please list them here _____

17. Are you currently being treated for any other medical conditions? ..... ☐ Yes ☐ No

If yes please list them here _____

I have answered these questions accurately and completely. I understand that my medical history is a very important factor in the development of my fitness/wellness program. Medical or physical conditions which are known to me, but which I do not disclose to the staff may result in serious injury to me. If any of the above conditions change, I will immediately inform the FOH Fitness Professional. I knowingly and willingly assume all risks of injury resulting from my failure to disclose accurate, complete and updated information in accordance with the above questionnaire.

Employee Signature: _____ **Date:** _____

FOH Staff Signature: _____ **Date:** _____

☐ **Cleared for exercise testing/exercise program**
☐ **Medical Clearance Required or Assumption of Risk Form Completed**