CAMPUS REC

Technician Use Only
Height _____
Weight _____

Medical History Questionnaire/
Human Performance Lab Health Screening Form

Date_____

Name _____ Age _____ Date of Birth _____ Gender _____

Phone _____ Occupation _____

Email address _____

Please answer the following questions as honestly as you can. Your patterns of responses will determine whether you may participate in either an exercise test or training program.

Known Diseases (Medical Conditions)

1. List the medications you take on a regular basis.
   (Include aspirin, vitamins & minerals, prescription and non-prescription)

   _____

   _____

2. Do you have diabetes? _____No _____Yes
   a. If yes, please indicate if it is insulin dependent diabetes mellitus (IDDM) or non-insulin dependent diabetes mellitus (NIDDM). _____IDDM _____NIDDM
3. Have you had a stroke? _____No _____Yes
4. Have you ever had a heart attack or heart trouble? _____No _____Yes
5. Do you take asthma medication? _____No _____Yes
6. Are you, or do you have reason to believe, you may be pregnant _____No _____Yes
7. Is there any other physical reason that prevents you from participating in an exercise program (e.g. cancer, osteoporosis, severe arthritis, mental illness, thyroid, kidney or liver disease)? _____No _____Yes

Signs and Symptoms of Disease

8. Do you often have pains in your heart, chest, neck, jaw, arms or other areas, especially during exercise? _____No _____Yes
9. Do you often feel faint or have spells of severe dizziness during exercise? _____No _____Yes
10. Do you experience unusual fatigue or shortness of breath at rest or with mild exertion? _____No _____Yes
11. Have you had an attack of shortness of breath that came on after you stopped exercising? _____No _____Yes
12. Have you been awakened at night by an attack of shortness of breath? _____No _____Yes
13. Do you experience swelling or accumulation of fluid in or around your ankles? _____No _____Yes
14. Do you often get the feeling that your heart is beating faster, racing, or skipping beats, either at rest or during exercise? _____No _____Yes
15. Do you regularly get pains in you calves or lower legs during exercise which are not due to soreness or stiffness? _____No _____Yes
16. Has your doctor ever told you that you have a heart murmur? _____No _____Yes

Cardiac Risk Factors

17. Do you or did you smoke cigarettes on a daily basis? _____No _____Yes
    a. If you did smoke when did you quit? (mm/dd/yy) _____
18. Has your doctor ever told you that you have high blood pressure? _____No _____Yes
19. Has a first degree relative (e.g. father, mother, sister, brother, or child) suffered from a heart attack or diagnosed cardiovascular disease? _____No _____Yes

Relative	Age	Did they pass away?

Current Physical Activity Patterns and Future Intentions

1. Does your job involve sitting for a large part of the day? _____No _____Yes

2. What are your current physical activity patterns?
   a) Frequency: _____activity sessions per week
   b) Intensity: _____Sedentary _____Moderate _____Vigorous
   c) Duration: _____minutes per session (on the average)
   d) How long have you been following this routine (check one)?
   _____Less than 3 months _____3-6 months _____6-12 months _____More than a year

3. What types of exercises do you <u>regularly</u> do? Please check all that apply.

_____Walking	_____Running	_____Stair-stepping	_____Yoga
_____Brisk Walking	_____Elliptical machine	_____Weight-lifting	_____Cycling
_____Swimming	_____Basketball/Volleyball	_____Racquet sports	_____Pilates

Other: _____

4. Are you interested in changing your activity routine? If so, please explain.
_____
_____
_____

5. What are your fitness goals?
_____
_____
_____

6. How committed are you to improving your fitness at this time?
_____
_____
_____