INITIAL HEALTH HISTORY QUESTIONNAIRE AND EVALUATION FORM

CONSENT

As part of my participation in a lifestyle management, disease prevention, disease management, or cardiac rehabilitation program that includes any of the INTERxVENTUSA, Inc. Lifestyle Management and Cardiovascular Risk Reduction Programs, I hereby release to INTERxVENTUSA, Inc. and authorize the use and disclosure of my individually identifiable health information as described below:
Specific description of the information to be released: All information gathered that is related to my participation in any INTERxVENT Program, including but not limited to information related to general physical status, mental illness, alcohol use, AIDS status, and genetic information (the "Protected Health Information").
Use of the information: I understand that INTERxVENTUSA, Inc. will use my Protected Health Information for the following purposes:

- research, including analysis of individual and aggregate data;
- quality control and review;
- continued improvement of the INTERxVENT Program; and
- continuity of the INTERxVENT Program services provided to me.

I understand that INTERxVENTUSA, Inc. will treat my Protected Health Information as confidential. My individual identifiable Protected Health Information will not be provided by INTERxVENTUSA, Inc. to other third parties without my further consent.

I understand that this authorization will remain in effect, unless revoked by me by notifying INTERxVENTUSA, Inc. in writing. However, I acknowledge that my revocation will not have any effect on any actions taken before the revocation.

Signature (Participant): _____

Date: _____

INITIAL HEALTH HISTORY QUESTIONNAIRE AND EVALUATION FORM: INSTRUCTIONS

This is your health history questionnaire and initial evaluation form for your participation in an INTERxVENTUSA Program. We will use this information to help evaluate your health and design an individual lifestyle management program for you. Obviously, you will want to make it as accurate and complete as possible.

Please complete all pages FRONT and BACK and print your responses in ink. Place a check mark in appropriate boxes or circles, where applicable.

THANK YOU !

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Initial Health History Questionnaire (Part I)

Please Note: Items in bold AND with an asterisk * are MANDATORY and should always be completed

General Information

Date of Questionnaire (mm/dd/yyyy) * _____

Name Prefix/Title * ○ Mr ○ Mrs ○ Miss ○ Ms ○ Dr ○ Sir ○ Lady

Other Name Prefix/Title (if not above) _____

First Name * _____ Middle Name _____

Last Name * _____

Suffix ○ Junior ○ Senior Other Suffix Name (if not in previous list): _____

Nickname or Name Used _____ Mother's Maiden Name _____

Email Address * _____

First Line Of Address * _____

Second Line Of Address _____

City * _____ **State Or Province *** _____

Zip Code * _____ **Country *** _____

Home Phone No. + Area Code * _____ Work Phone Number + Area Code _____

Fax Number + Area Code _____ Mobile Phone Number + Area Code _____

Preferred Contact Method(s) * ☐ Home Telephone ☐ Work Telephone ☐ Mobile Telephone ☐ Email ☐ Fax

Preferred Contact Time(s) * ☐ Before 10AM ☐ 10AM-2PM ☐ 2PM-6PM ☐ After 6PM

...And Your Associated Time Zone * ○ EST ○ CST ○ PST ○ MST ○ Other

If Other, please provide details _____

Occupation _____ **Occupational Status *** ○ Active ○ Retired

Company / Employer * _____ Please state NONE if not relevant

The following apply to the SPOUSE of the Participant (all optional):

Name Prefix/Title ○ Mr ○ Mrs ○ Miss ○ Ms ○ Dr ○ Sir ○ Lady

Other Name Prefix/Title (if not above) _____

Spouse First Name _____ Spouse Middle Name _____

Spouse Last Name _____ Spouse Suffix _____

Spouse Occupation _____ Spouse Occupational Status ○ Active ○ Retired

Spouse Employer _____ Spouse Work Tel No. + Area Code _____

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Initial Health History Questionnaire (Part I)

Reasons For Participating

☐ Referred By Physician

☐ Referred By Other Health Professional

Please Provide His/Her Name _____

☐ Referred By Another INTERxVENT Member

Please Provide His/Her Name _____

Other Reasons For Participating (check all that apply)

☐ Heart Disease/Stroke Prevention

☐ Weight Management

☐ Cholesterol and/or Triglycerides Management

☐ Blood Pressure Management

☐ Diabetes Management

☐ Exercise Program

☐ Dietary/Nutrition Program

☐ Smoking Cessation

☐ Stress Management

Other Reasons _____

Personal Profile

Date Of Birth (mm/dd/yyyy) * _____

Gender * ◯ Male ◯ Female

Race * ◯ African American ◯ Asian ◯ Hispanic ◯ Caucasian

Other Race (Please Specify) _____

Current Marital Status * ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Number of Children _____

People Living With You * ☐ Live Alone ☐ Spouse ☐ Children ☐ Parents ☐ In-Laws ☐ Other

Education (Check Highest Level Attained) *

Grade ◯ 6 Or Less ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12

College ◯ 1 ◯ 2 ◯ 3 ◯ 4 Or More Years

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Initial Health History Questionnaire (Part I)

Physician Information

Do you have a physician? * ◯ Yes ◯ No

If No, leave questions 1, 2 and 3 blank and go to question number 4 below

1. If you were referred by a physician, please provide his / her details

Last Name _____

First Name _____

First Line Of Address _____

Second Line Of Address _____

City _____

State Or Province _____

Zip Code _____

Type of Specialty _____

2. If you were NOT referred by a physician, or if the physician who referred you is NOT your primary care physician, please provide the following information about your primary care physician

Last Name _____

First Name _____

First Line Of Address _____

Second Line Of Address _____

City _____

State Or Province _____

Zip Code _____

3. When applicable, INTERVENT-USA or its Business Associate (as defined under 45 CFR Section 106.103), may send such reports and medical clearance documents to and receive information specifically required for the INTERVENT Project selected by me from my physicians listed above. ◯ Yes ◯ No ◯ Unknown

4. Has a medical doctor ever told you that you have:

(i) One or more blockages (including partial blockages) in your heart's arteries (that is, your coronary arteries)? * ◯ Yes ◯ No

(ii) A blockage (including partial blockages) in a carotid artery (that is, the major arteries in your neck)? * ◯ Yes ◯ No

(iii) Pain on exertion in your hips, buttocks, legs, and/or calves that is a result of blockages in your arteries? * ◯ Yes ◯ No

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Initial Health History Questionnaire (Part I)

Medications

1. General Medications

Do you currently take any of the following medications on a daily (or regular) basis? *

- ☐ Medication for angina (that is, chest pain or discomfort due to blockages in your heart's coronary arteries)?
- ☐ Medication for heart failure?
- ☐ Medication for high blood pressure?
- ☐ Medication for blood cholesterol or triglyceride levels?
- ☐ Medication for diabetes?
- ☐ Aspirin, Plavix, Ticlid, Aggrenox, or Coumadin?
- ☐ Confirmation Only:

  I do not take any of the above medications on a regular basis.

2. Specific Medications

Please list all of the medications that you take below (Dosage is the amount of medication, for example, 50 mg or 5 ml. If you are unsure, leave the Dosage and Frequency blank.) Please list prescription and over-the-counter medications, including vitamins.

Medication Name	Dosage (amount)	Frequency (times per day)

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Initial Health History Questionnaire (Part I)

Past Surgery Details

Check the box in the column marked Include for all past MAJOR surgery items that apply to you from the list below. If you do not know the approximate date of the surgery, leave this field blank. (If known, you may enter the month and year, or only the year of the surgery.)

Include?	Month (mm)	Year (yyyy)	Description of Major Surgery
☐			Angioplasty (PTCA)
☐			Stent
☐			Atherectomy
☐			CABG (Coronary Artery Bypass Graft Surgery)
☐			Carotid Endarterectomy
☐			Surgery to alleviate pain on exertion in your hips, buttocks, legs, and/or calves resulting from blockages in your arteries

If you cannot find a MAJOR surgery item in the list above, please add other MAJOR surgeries below.

Include?	Month (mm)	Year (yyyy)	Description of Surgery
☐			
☐			
☐			
☐			
☐			

Past Injury Details

Please add brief details of all SERIOUS injuries you have had below. If you do not know the approximate date of the serious injury, leave this field blank. (If known, you may enter the month and year, or only the year of the serious injury.)

Include?	Month (mm)	Year (yyyy)	Description of Serious Injury
☐			
☐			
☐			
☐			
☐			

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Initial Health History Questionnaire (Part I)

Medical Problems

Check the box in the column marked Include for all SIGNIFICANT Medical Problems you have ever experienced at any time in your life, past or present. If you know the Onset Date for the problem, please enter the month number (1 to 12 - if known) and the year (yyyy - if known) (leave blank if unknown). Additionally, check the box in the column marked Still A Problem for those that are still currently a problem.

General Conditions

Include?	Onset Date Month and Year	Still A Problem?		Problem Description	Comments
☐	_____	☐	(1)	Chronic fatigue	_____
☐	_____	☐	(2)	Any type of cancer	_____

Heart / Circulation

Include?	Onset Date Month and Year	Still A Problem?		Problem Description	Comments
☐	_____	☐	(3)	Chest pain or discomfort	_____
☐	_____	☐	(4)	Discomfort in neck, jaw, arms, upper back, or abdomen with exertion	_____
☐	_____	☐	(5)	Shortness of breath with mild exertion	_____
☐	_____	☐	(6)	Heart attack	_____
☐	_____	☐	(7)	Bypass surgery	_____
☐	_____	☐	(8)	Angioplasty /stent /atherectomy	_____
☐	_____	☐	(9)	Heart valve surgery	_____
☐	_____	☐	(10)	Heart transplant	_____
☐	_____	☐	(11)	Pacemaker	_____
☐	_____	☐	(12)	A.I.C.D (Automatic Defibrillator)	_____
☐	_____	☐	(13)	Other heart / vascular surgery	_____
☐	_____	☐	(14)	Congenital heart defect	_____
☐	_____	☐	(15)	Heart failure/Congestive heart failure (CHF)	_____
☐	_____	☐	(16)	Cardiomyopathy	_____
☐	_____	☐	(17)	Viral infection of the heart	_____
☐	_____	☐	(18)	Heart murmur or valve problem	_____
☐	_____	☐	(18A)	Aneurysm of the aorta (aortic aneurysm)	_____
☐	_____	☐	(19)	Ankle swelling	_____
☐	_____	☐	(20)	Get up at night to urinate	_____
☐	_____	☐	(21)	Shortness of breath while sleeping	_____
☐	_____	☐	(22)	Rapid / irregular heartbeats	_____

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Initial Health History Questionnaire (Part I)

Medical Problems

Heart / Circulation

Include?	Onset Date Month and Year	Still A Problem?		Problem Description	Comments
☐	_____	☐	(23)	Fainting / lightheadedness	_____
☐	_____	☐	(24)	High blood pressure	_____
☐	_____	☐	(25)	Blockage in artery to the legs	_____
☐	_____	☐	(26)	Blockage in carotid arteries	_____
☐	_____	☐	(27)	Transient Ischemic Attack (T.I.A. or 'mini-stroke')	_____
☐	_____	☐	(28)	Stroke	_____
☐	_____	☐	(29)	High blood cholesterol	_____
☐	_____	☐	(30)	High blood triglycerides	_____
☐	_____	☐	(31)	Other heart or circulatory problems	_____

Endocrine

Include?	Onset Date Month and Year	Still A Problem?		Problem Description	Comments
☐	_____	☐	(32)	Thyroid disease	_____
☐	_____	☐	(33)	High blood sugar	_____
☐	_____	☐	(34)	Diabetes	_____

Pulmonary

Include?	Onset Date Month and Year	Still A Problem?		Problem Description	Comments
☐	_____	☐	(35)	Asthma	_____
☐	_____	☐	(36)	Bronchitis	_____
☐	_____	☐	(37)	Emphysema	_____

Gastrointestinal

Include?	Onset Date Month and Year	Still A Problem?		Problem Description	Comments
☐	_____	☐	(38)	Ulcer disease	_____
☐	_____	☐	(39)	Gallbladder trouble	_____
☐	_____	☐	(40)	Jaundice, hepatitis, cirrhosis, or other liver disease	_____
☐	_____	☐	(41)	Eating disorder - anorexia	_____
☐	_____	☐	(42)	Eating disorder - bulimea	_____

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Initial Health History Questionnaire (Part I)

Medical Problems

Genitourinary

Include?	Onset Date Month and Year	Still A Problem?		Problem Description	Comments
☐	_____	☐	(43)	Kidney disease / Renal disease	_____
☐	_____	☐	(43A)	Kidney failure / Renal failure	_____
☐	_____	☐	(43B)	Kidney dialysis / Renal dialysis	_____

Bone And Joint

Include?	Onset Date Month and Year	Still A Problem?		Problem Description	Comments
☐	_____	☐	(44)	Low back pain	_____
☐	_____	☐	(45)	Arthritis	_____
☐	_____	☐	(46)	Gout	_____
☐	_____	☐	(47)	Osteoporosis	_____
☐	_____	☐	(48)	Marfan's Syndrome	_____
☐	_____	☐	(49)	Fibromyalgia	_____

Neuropsychiatric

Include?	Onset Date Month and Year	Still A Problem?		Problem Description	Comments
☐	_____	☐	(50)	Seizures or epilepsy	_____
☐	_____	☐	(51)	Numbness or tingling of arms, legs, or face	_____
☐	_____	☐	(52)	Depression	_____
☐	_____	☐	(53)	Anxiety	_____
☐	_____	☐	(54)	Thoughts of suicide	_____
☐	_____	☐	(55)	Psychiatric or psychological counseling	_____

Hematology

Include?	Onset Date Month and Year	Still A Problem?		Problem Description	Comments
☐	_____	☐	(56)	Anemia	_____
☐	_____	☐	(57)	Blood clotting deficiency / bleeding disorder / blood clots in legs or lungs	_____
☐	_____	☐	(58)	HIV/AIDS	_____

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Initial Health History Questionnaire (Part I)

Medical Problems

Enter SIGNIFICANT Medical Problems (not found in the above list) you have ever experienced at any time in your life, past or present. If you do not know the approximate date that the medical problem first occured you may leave this field blank. (If known, you may enter the month and year, or just the year of the medical problem). Additionally, check the box marked Still A Problem for those which are still currently a problem.

Include?	Onset Date Month and Year	Still A Problem?	Problem Description
☐	_____	☐	_____
☐	_____	☐	_____
☐	_____	☐	_____

Additional Comments _____

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Initial Health History Questionnaire (Part I)

Gynecological & Family History

Gynecological History (Females Only)

If the answer is YES for any of these quesetions, please check the box alongside the question:

- ☐ Do you still have your menstrual periods?
- ☐ Have you had a hysterectomy?
- ☐ If you have had a hysterectomy, were your ovaries removed?
- ☐ Are you currently taking birth control pills?
- ☐ Are you currently taking hormone replacement therapy?
- ☐ Have you ever had breast cancer?
- ☐ Are you currently pregnant?
- ☐ Are you currently breast feeding?
- ☐ Confirmation Only:
  None of the above gynecological questions apply to me.

Family History

Family illnesses: Have your parents, sisters, brothers, or children developed any of the following? Exclude relatives by marriage or adoption. If YES, please check the appropriate box.

- ☐ Heart attacks under age 55 if male or 65 if female
- ☐ Bypass surgery under age 55 if male or 65 if female
- ☐ Angioplasty under age 55 if male or 65 if female
- ☐ Angina under age 55 if male or 65 if female
- ☐ Strokes under age 55 if male or 65 if female
- ☐ Sudden unexplained death under age 55 if male or 65 if female
- ☐ High cholesterol or triglycerides
- ☐ Diabetes
- ☐ Breast cancer
- ☐ Your family history is wholly (or partly) unknown
- ☐ Confirmation Only:
  None of the above family history questions apply to me.

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Initial Health History Questionnaire (Part I)

Tobacco Use & Alcohol Use

Tobacco Use

1. Do you CURRENTLY use tobacco? *(If no, go to question 4) ○ Yes ○ No

a. If you smoke cigarettes now, how many per day? _____

b. If you smoke cigars now, how many per day? _____

c. If you smoke a pipe now, how many pipefuls per day? _____

d. If you use 'smokeless' tobacco now, how many times per day? _____

2. How ready (or motivated) are you to quit tobacco use at present? Check the appropriate number.

(0=Not ready, 5=somewhat ready, 10=very ready)

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

3. What are the major obstacles to your quitting tobacco?

_____

4. If you DO NOT CURRENTLY smoke or use tobacco products, have you in the past...

☐ Smoked cigarettes? If YES, what year did you quit? _____ (yyyy)

☐ Smoked cigars? If YES, what year did you quit? _____ (yyyy)

☐ Smoked a pipe? If YES, what year did you quit? _____ (yyyy)

☐ Used 'smokeless' tobacco? If YES, what year did you quit? _____ (yyyy)

5. Do you live with people who smoke? * ○ Yes ○ No

6. If you currently use tobacco or if you used tobacco in the past, what is the total number of years you have used tobacco? _____ (years)

7. If you currently use tobacco or if you used tobacco in the past, check the one statement that best reflects your current use of tobacco products:

I am currently using tobacco, and I do not intend to stop using tobacco in the next six months; ○

I am currently using tobacco, but I intend to stop using tobacco in the next six months; ○

I am currently using tobacco, but I intend to stop using tobacco in the next month; ○

I have not used tobacco at all for less than the past six months; ○

I have not used tobacco at all for the past 6 months or more. ○

Alcohol Use

1. Do you drink alcoholic beverages? * ○ Yes ○ No

If YES, how many drinks per week?
(1 Drink=12oz or 360mL beer; 5oz or 150mL wine; 1oz or 30mL liquor) _____

2. Do you now have or have you ever had problems with excessive alcohol use? * ○ Yes ○ No

3. If you drink more than an average of two alcoholic drinks each day, how ready (or motivated) are you to cut down or quit?

(0=Not ready, 5=somewhat ready, 10=very ready)

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

4. If you drink more than an average of two alcoholic drinks each day, what are the major obstacles to your cutting down or quittin

_____

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Initial Health History Questionnaire (Part I)

Body Weight & Nutrition Information

Body Weight

1. What do you consider a good weight for yourself? _____ **pounds (Lbs) ***

Nutrition

1. Are you currently on any diet or dietary restriction? ◯ Yes ◯ No

If YES, check the appropriate description below:

- ☐ Low Fat
- ☐ Low Cholesterol
- ☐ Low Sodium (salt)
- ☐ Vegetarian
- ☐ Low Calorie (weight reduction)
- ☐ Diabetic Diet

Other (please specify): _____

Who (if anyone) supervises or sponsors the dietary program? _____

How long have you been following the dietary program?

◯ N/A ◯ Just started ◯ 0-1 month ◯ 2-3 months ◯ 4-6 months ◯ More than 6 months

2. Have you ever received counselling from a dietitian? * ◯ Yes ◯ No

3. Have you ever participated in a weight loss/management program? ◯ Yes ◯ No

If YES, check any program(s) you have participated in:

☐ Jenny Craig ☐ Nutri/System ☐ Physicians Weight Loss Centers ☐ Weight Watchers

Other (please specify): _____

4. Do you ever think about eating more healthy? * ◯ Yes ◯ No

5. If YES to #4, how ready (or motivated) are you to change your eating habits?

(0=Not ready, 5=somewhat ready, 10=very ready)

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

6. What are your major obstacles to eating more healthy?

_____

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Initial Health History Questionnaire (Part I)

Aerobic And Muscle Strengthening Activities

1. Are you currently involved in a routine of regular aerobic exercise (moderate continuous exertion of at least 20 minutes 3 times per week)? * ◯ Yes ◯ No

2. How long have you been exercising regularly?

_____ Years _____ Months _____ Weeks

3. During the PAST FOUR WEEKS, which of the following aerobic activities have you performed regularly (please check all that apply and provide details)?

☐ **Walking**

How many workouts per week? _____ Average duration per workout _____ (mins)

☐ **Treadmill**

How many workouts per week? _____ Average duration per workout _____ (mins)

☐ **Stationary Cycling**

How many workouts per week? _____ Average duration per workout _____ (mins)

☐ **Other Aerobic Exercise Machine**

Enter Machine Type _____

How many workouts per week? _____ Average duration per workout _____ (mins)

☐ **Aerobic Dance or Floor Exercises**

How many workouts per week? _____ Average duration per workout _____ (mins)

☐ **Jogging or Running**

How many workouts per week? _____ Average duration per workout _____ (mins)

☐ **Bicycling (outdoors)**

How many workouts per week? _____ Average duration per workout _____ (mins)

☐ **Swimming Laps**

How many workouts per week? _____ Average duration per workout _____ (mins)

☐ **Racquet Sports (e.g. Racquetball, Tennis)**

Enter Racquet Sport _____

How many workouts per week? _____ Average duration per workout _____ (mins)

☐ **Other Aerobic Activity**

Other Activity _____

How many workouts per week? _____ Average duration per workout _____ (mins)

Muscle Strengthening Activities

1. Are you currently involved in a muscle strengthening program? * ◯ Yes ◯ No

If YES, what type? ☐ Calisthenics ☐ Free Weights ☐ Weight Training Machines

Other (please specify): _____

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Initial Health History Questionnaire (Part I)

Physical Activity Resources

1. What exercise equipment, if any, do you own?

Please check any Exercise Equipment items that you own in the list below.

Include?	Exercise Equipment
☐	Bicycle
☐	Cross Country Ski Simulator
☐	Heart (or pulse) rate monitor
☐	Rowing Machine
☐	Running / Walking Shoes
☐	Stationary Cycle
☐	Treadmill

If you cannot find an item in the list above, please add brief details below.

Include?	Exercise Equipment
☐	_____
☐	_____
☐	_____

2. To what exercise facilities do you have access?

Please check any Exercise Facilities to which you have access from the list below.

Include?	Exercise Facility
☐	Aerobic Exercise Class
☐	Bicycle Path
☐	Health Club/Fitness Club
☐	Jogging / Walking Path
☐	Shopping Mall
☐	Suitable Area for Walking
☐	Swimming Lap Pool

If you cannot find an item in the list above, please add brief details below.

Include?	Exercise Facility
☐	_____
☐	_____
☐	_____

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Initial Health History Questionnaire (Part I)

Physical Activity Resources

3. What types of aerobic exercise activities (e.g. walking, jogging, stationary cycling) would you like to include in any exercise plan that you might do?
Please check any Aerobic Exercise Activities, which you would like to include in an exercise plan that you might do, in the list below.

Include?	Aerobic Exercise Activity
☐	Aerobic Dance or Floor Exercises
☐	Bicycling Outdoors
☐	Cross-Country Skiing Machine
☐	Health Rider
☐	Jogging or Running
☐	Racquet Sports
☐	Stair Climbing - Stepping
☐	Stationary Cycling
☐	Swimming Laps
☐	Treadmill
☐	Walking
☐	Water Aerobics

If you cannot find an item in the list above, please add brief details below.

Include?	Exercise Activity
☐	_____
☐	_____

4. If you are NOT exercising regularly, do you ever think about getting started with a program of regular exercise? ○ Yes ○ No

5. If you are NOT exercising regularly, how ready (or motivated) are you to get started with a program of regular exerci
(0=Not ready, 5=somewhat ready, 10=very ready)

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

6. If you are NOT exercising regularly, what are the major obstacles to your starting? _____

7. If you were previously participating in an exercise program BUT NO LONGER ARE DOING SO, why did you quit? _____

8. Would you prefer to exercise in a group? * ○ Yes ○ No

9. Are you a member of a fitness/health club? * ○ Yes ○ No **If NO, would you like to join one? *** ○ Yes ○ No

Occupation-Related Physical Activity

10. How active are you at work on most days?

☐ Sedentary (mostly sitting or standing) ☐ Moderately active (walking, light work some of the time)

☐ Active (walking, light/moderate work) ☐ Very Active (walking more than half the time, heavy work)

Exercise Safety

11. Do you have any bone, joint, muscle, or other orthopedic problems that could be worsened by exercise? *

○ Yes ○ No If Yes, please provide brief details _____

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Initial Health History Questionnaire (Part I)

Well-Being, Stress and Emotional Factors

1. In general, would you say your health is: *

◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

2. COMPARED TO ONE YEAR AGO, how would you rate your health in general now? *

◯ Much better now than one year ago ◯ Somewhat better now than one year ago ◯ About the same as one year ago
◯ Somewhat worse now than one year ago ◯ Much worse now than one year ago

3. These questions are about how you feel and how things have been with you during the PAST FOUR WEEKS. Please choose the one answer closest to the way you have been feeling.

a. Did you feel full of pep? *

◯ All ◯ Most ◯ Good Bit ◯ Some ◯ Little ◯ None of the time

b. Have you been a very nervous person? *

◯ All ◯ Most ◯ Good Bit ◯ Some ◯ Little ◯ None of the time

c. Have you felt so down in the dumps that nothing could cheer you up? *

◯ All ◯ Most ◯ Good Bit ◯ Some ◯ Little ◯ None of the time

d. Have you felt calm and peaceful? *

◯ All ◯ Most ◯ Good Bit ◯ Some ◯ Little ◯ None of the time

e. Did you have a lot of energy? *

◯ All ◯ Most ◯ Good Bit ◯ Some ◯ Little ◯ None of the time

f. Have you felt downhearted and blue? *

◯ All ◯ Most ◯ Good Bit ◯ Some ◯ Little ◯ None of the time

g. Did you feel worn out? *

◯ All ◯ Most ◯ Good Bit ◯ Some ◯ Little ◯ None of the time

h. Have you been a happy person? *

◯ All ◯ Most ◯ Good Bit ◯ Some ◯ Little ◯ None of the time

i. Did you feel tired? *

◯ All ◯ Most ◯ Good Bit ◯ Some ◯ Little ◯ None of the time

4. What is your greatest source of worry or concern at present? *

◯ Marriage ◯ Family ◯ Job ◯ Finances ◯ Health ◯ Other

5. How ready (or motivated) are you to learn to manage the stress and tension in your life? *

(0=Not ready, 5=somewhat ready, 10=very ready)

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

6. What are the major obstacles to your reducing the amount of stress and tension in your life? _____

7. How do you spend your leisure time? _____

Medications

1. From time to time, many people find it difficult to take prescribed medication. Please estimate how often you do not take your medications as directed by your doctor. *

◯ Never take it ◯ Take it less than half the time ◯ Take it about half the time ◯ Take it more than half the time ◯ Always take it

2. What are the main reasons for not taking your medications as prescribed?

☐ Forgot to take medications ☐ Medications were lost ☐ Medications were too expensive ☐ Medications ran out

Other reasons: _____

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Initial Health History Questionnaire (Part II)

Diagnostic Studies & Drug Allergies

Diagnostic Studies

Please select Diagnostic Studies you have ever had from the list below.

Include?	Description of Diagnostic Study	Test Result	Taken Within Last 12 Months?*
☐	Heart Catheterization (Dye Test Of Heart)	◯ Normal ◯ Abnormal ◯ Unknown	☐
☐	Heart Scan (e.g. Ultrafast CT Scan, EBT)	◯ Normal ◯ Abnormal ◯ Unknown	☐
☐	Heart Ultrasound Exam (Echocardiogram)	◯ Normal ◯ Abnormal ◯ Unknown	☐
☐	Thallium / Nuclear Medicine Stress Test	◯ Normal ◯ Abnormal ◯ Unknown	☐
☐	Treadmill or Cycle Stress Test (Exercise Test)	◯ Normal ◯ Abnormal ◯ Unknown	☐

If you cannot find a heart, blood vessel or brain-related Diagnostic Study item in the list above, please give brief details below

☐	_____	◯ Normal ◯ Abnormal ◯ Unknown	☐
☐	_____	◯ Normal ◯ Abnormal ◯ Unknown	☐
☐	_____	◯ Normal ◯ Abnormal ◯ Unknown	☐
☐	_____	◯ Normal ◯ Abnormal ◯ Unknown	☐

Drug Allergies

Please add the name of the medication to which you are allergic below.

Medication to which you are allergic:	Reaction to medication:
_____	_____
_____	_____
_____	_____

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Initial Health History Questionnaire (Part II)

Further Body Weight and Nutritional Information

Body Weight

1. What was your highest weight after age 18 (exclude pregnancy)?

_____ pounds (Lbs) At what age? _____

2. What was your lowest weight after age 18 (exclude illness)?

_____ pounds (Lbs) At what age? _____

3. Weight loss history: How many times in your life would you estimate you have lost the weights shown below?

Lost 5 Lbs (2.3 kg)	_____	times
Lost 10 Lbs (4.5 kg)	_____	times
Lost 20 Lbs (9.1 kg)	_____	times
Lost 30 Lbs (13.6 kg)	_____	times
Lost 50 Lbs (22.7 kg)	_____	times
Lost 80 Lbs (36.4 kg)	_____	times
Lost 100 Lbs (45.5 kg) or more	_____	times

Nutrition

1. How often do you eat these high-protein vegetable or meat products (exclude fried foods)?

a. Soy products / beans *

◯ Rarely or Never ◯ 1-2 times/week ◯ 3-5 times/week ◯ 6 or more times/week

b. Fish *

◯ Rarely or Never ◯ 1-2 times/week ◯ 3-5 times/week ◯ 6 or more times/week

c. Chicken / turkey *

◯ Rarely or Never ◯ 1-2 times/week ◯ 3-5 times/week ◯ 6 or more times/week

d. Red meat *

◯ Rarely or Never ◯ 1-2 times/week ◯ 3-5 times/week ◯ 6 or more times/week

2. How often do you eat these dairy products?

a. Reduced fat or non-fat products such as : milk, cheese, frozen-yogurt, or ice cream *

◯ Rarely or Never ◯ 1-2 times/week ◯ 3-5 times/week ◯ 6 or more times/week

b. Whole milk or cream, regular cheese, regular ice cream, or whole eggs *

◯ Rarely or Never ◯ 1-2 times/week ◯ 3-5 times/week ◯ 6 or more times/week

3. How often do you eat high-fat snacks, chips, or fried food (e.g., doughnuts, pastry, pie, cake, cookies, chocolate candy, potato or corn chips, regular crackers, french fries, fried chicken, or pizza)? *

◯ Rarely or Never ◯ 1-2 times/week ◯ 3-5 times/week ◯ 6 or more times/week

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Initial Health History Questionnaire (Part II)

Further Body Weight and Nutritional Information

Nutrition (continued)

4. How often do you use these fats at the table or in cooking (i.e. sauces or gravy)? *

a. Margarine *

◯ Rarely or Never ◯ Less than once/day ◯ 1-2 times/day ◯ 3 or more times/day

b. Butter *

◯ Rarely or Never ◯ Less than once/day ◯ 1-2 times/day ◯ 3 or more times/day

5. How many servings of fruit and vegetables do you eat per day? A serving of fruit is 1 med. piece, 1/2 cup cut up, 1/2 cup of 100% real juice, or 1/4 cup dried fruit. A serving of vegetables is 1 cup of raw vegetables or salad, or 1/2 cup cooked. *

◯ Rarely or Never ◯ 1-2 servings/day ◯ 3-5 servings/day ◯ 6 or more servings/day

6. How many times EACH WEEK do you eat this meal?

a. Breakfast *

◯ Zero times/wk ◯ 1/wk ◯ 2/wk ◯ 3/wk ◯ 4/wk ◯ 5/wk ◯ 6/wk ◯ 7/wk

b. Lunch *

◯ Zero times/wk ◯ 1/wk ◯ 2/wk ◯ 3/wk ◯ 4/wk ◯ 5/wk ◯ 6/wk ◯ 7/wk

c. Dinner *

◯ Zero times/wk ◯ 1/wk ◯ 2/wk ◯ 3/wk ◯ 4/wk ◯ 5/wk ◯ 6/wk ◯ 7/wk

7. When you eat away from home, how often do you choose low-fat items? *

◯ Rarely or Never ◯ Less than 1/2 of the time ◯ More than 1/2 of the time ◯ Nearly all of the time

8. How many of each of the following sugar-containing beverages do you consume in an average day? *

Regular soft drinks (12 oz. or 360 mL) _____ /day

Iced tea (sweetened, 12 oz. or 360 mL) _____ /day

9. How often do you add salt to your food after it is served to you? *

◯ Rarely or Never ◯ Sometimes ◯ Always (at every meal)

10.How often do you add salt in cooking or preparing food? *

◯ Rarely or Never ◯ Sometimes ◯ Always ◯ I don't know if salt is added in cooking

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Initial Health History Questionnaire (Part II)

Well-being, Stress and Emotional Factors

1. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

a. VIGOROUS activities e.g. running, lifting heavy objects, strenuous sports *

◯ Yes, limited a lot ◯ Yes, limited a little ◯ No, Not limited at all

b. MODERATE activities e.g. moving a table, pushing a vacuum cleaner, playing golf *

◯ Yes, limited a lot ◯ Yes, limited a little ◯ No, Not limited at all

c. Lifting or carrying groceries *

◯ Yes, limited a lot ◯ Yes, limited a little ◯ No, Not limited at all

d. Climbing SEVERAL flights of stairs *

◯ Yes, limited a lot ◯ Yes, limited a little ◯ No, Not limited at all

e. Climbing ONE flight of stairs *

◯ Yes, limited a lot ◯ Yes, limited a little ◯ No, Not limited at all

f. Bending, kneeling, or stooping *

◯ Yes, limited a lot ◯ Yes, limited a little ◯ No, Not limited at all

g. Walking MORE THAN ONE MILE *

◯ Yes, limited a lot ◯ Yes, limited a little ◯ No, Not limited at all

h. Walking SEVERAL BLOCKS *

◯ Yes, limited a lot ◯ Yes, limited a little ◯ No, Not limited at all

i. Walking ONE BLOCK *

◯ Yes, limited a lot ◯ Yes, limited a little ◯ No, Not limited at all

j. Bathing or dressing yourself *

◯ Yes, limited a lot ◯ Yes, limited a little ◯ No, Not limited at all

2. During the PAST FOUR WEEKS, have you had any of the following problems with your work or other regular daily activities AS A RESULT OF YOUR PHYSICAL HEALTH?

a. Cut down the amount of time you spent on work or other activities *

◯ Yes ◯ No

b. Accomplished less than you would like *

◯ Yes ◯ No

c. Were limited in the kind of work or other activities *

◯ Yes ◯ No

d. Had difficulty performing work or other activities (e.g. it took extra effort) *

◯ Yes ◯ No

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Initial Health History Questionnaire (Part II)

Well-being, Stress and Emotional Factors

3. During the PAST FOUR WEEKS, have you had any of the following problems with your work or other regular daily activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling anxious or depressed)?

a. Cut down the amount of time you spent on work or other activities *
◯ Yes ◯ No

b. Accomplished less than you would like *
◯ Yes ◯ No

c. Didn't do work or other activities as carefully as usual *
◯ Yes ◯ No

4. During the PAST FOUR WEEKS, to what extent has your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your normal social activities with family, friends, neighbors, or groups? *

◯ Not at all ◯ Slightly ◯ Moderately ◯ Quite a bit ◯ Extremely

5. How much BODILY pain have you had during the PAST FOUR WEEKS? *

◯ None ◯ Very mild ◯ Mild ◯ Moderate ◯ Severe ◯ Very severe

6. During the PAST FOUR WEEKS, how much did pain interfere with your normal work (including both work outside the home and housework)? *

◯ Not at all ◯ Slightly ◯ Moderately ◯ Quite a bit ◯ Extremely

7. During the PAST FOUR WEEKS, how much of the time has your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting with your friends or relatives etc.)? *

◯ All ◯ Most ◯ Some ◯ Little ◯ None

8. How TRUE or FALSE is EACH of the following statements for you?

a. I seem to get sick a little easier than other people *
◯ Definitely True ◯ Mostly True ◯ Don't know ◯ Mostly False ◯ Definitely False

b. I am as healthy as anybody I know *
◯ Definitely True ◯ Mostly True ◯ Don't know ◯ Mostly False ◯ Definitely False

c. I expect my health to get worse *
◯ Definitely True ◯ Mostly True ◯ Don't know ◯ Mostly False ◯ Definitely False

d. My health is excellent *
◯ Definitely True ◯ Mostly True ◯ Don't know ◯ Mostly False ◯ Definitely False

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THANK YOU !

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