

**Performance Physical Therapy Fitness Center
Health/Medical History Questionnaire**

Name _____

Do you now or have you ever smoked? Yes No

If you previously smoked, how many years did you smoke? _____

How often did you smoke? _____

How long ago did you quit? _____

Do you consider yourself: (*check one*)

Sedentary Light exercise Moderately active Highly active

If active, what kind of exercise do you now do? _____

Would you characterize your life as: (*check one*)

Highly stressful Moderately stressful Low in stress

Medical History -- Please check the boxes next to any of the following conditions you now have, or have experienced in the past.

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart attack, coronary bypass or other cardiac surgery | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Increased anxiety or depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Emotional disorders |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Fatigue, lack of energy |
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Unusual shortness of breath | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Phlebitis, emboli | <input type="checkbox"/> Lightheadedness or fainting | <input type="checkbox"/> Migraine or recurring headache |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Epilepsy, seizures | <input type="checkbox"/> Swollen, stiff, or painful joints |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Chest discomfort | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Extra, skipped or rapid heart beats/palpitations | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Low back pain |
| | <input type="checkbox"/> Chronic, recurring cough | <input type="checkbox"/> Other (<i>list</i>) _____ |

Please explain any boxes you checked: _____

Please list any prescribed medications you are now taking: _____

Please list any over the counter medications or dietary supplements you are now taking:

Please list any illness, hospitalization or surgical procedure within the past two years:

Please give date of last physical examination and results: _____

Family History

Have any of your blood relatives had any of the following? *(Please check those that apply. Include grandparents, parents, aunts, uncles and siblings. Please list relative and age the incident occurred.)*

	Relation to you:	At what age?
<input type="checkbox"/> Heart attack	_____	_____
<input type="checkbox"/> Stroke	_____	_____
<input type="checkbox"/> Coronary disease	_____	_____
<input type="checkbox"/> Congenital heart disease	_____	_____
<input type="checkbox"/> High blood pressure	_____	_____
<input type="checkbox"/> Diabetes	_____	_____
<input type="checkbox"/> Coronary operations	_____	_____
<input type="checkbox"/> Elevated cholesterol	_____	_____

Fitness Goals

Please check / describe specific goals and rate their importance.

- | | | |
|---|--|--|
| <input type="checkbox"/> Improve strength | <input type="checkbox"/> Increase energy | <input type="checkbox"/> Improve flexibility |
| <input type="checkbox"/> Improve cardiovascular fitness | <input type="checkbox"/> Improve muscle shape / size | <input type="checkbox"/> Lose body weight / fat |
| <input type="checkbox"/> Gain weight / muscle | <input type="checkbox"/> Rehabilitate injury | <input type="checkbox"/> Injury prevention |
| <input type="checkbox"/> Improve diet / eating habits | <input type="checkbox"/> Reduce stress | <input type="checkbox"/> Stop smoking / drinking |
| <input type="checkbox"/> Additional goals (list): _____ | | |
