

Health History and Lifestyle Review

Name _____ Date of birth _____ Age _____
Home address _____
City _____ State _____ Zip _____
Telephone (home) _____ (office) _____
E-mail _____
Physician _____ Telephone _____
Address _____ Fax _____
Emergency contact _____ Telephone _____

MARITAL STATUS: M S D W Number of children: _____

HEALTH STATUS: Have you experienced any of the following or do any of the following apply to you? If yes, please explain:

_____ Heart operation, disease or problem _____
_____ Varicose veins _____
_____ Cirrhosis _____
_____ Phlebitis _____
_____ Stroke _____
_____ Current medication for high blood pressure or diabetes _____
_____ Cough up blood _____
_____ Pain in the abdomen, leg, arm, shoulder or chest _____
_____ Swollen joints _____
_____ Faintness or dizziness _____
_____ Breathless with slight exertion _____
_____ Swelling in ankles _____
_____ Pain or discomfort in the chest _____
_____ Known heart murmur _____
_____ Diabetes _____
_____ Pregnant or lactating _____
_____ High blood pressure (140/90+) _____
_____ High serum cholesterol (200+) _____
_____ Allergies or asthma _____
_____ Abnormal Electrocardiogram _____
_____ Respiratory Infections _____
_____ Embolism _____
_____ Aneurysm _____
_____ Valve Disease _____
_____ Epilepsy _____

Comments: _____

FAMILY HISTORY of diabetes, coronary or other cardiovascular disease prior to age 55:

Father _____
Mother _____
Siblings _____
Grandparents _____

MEDICATIONS you have taken within the last 6 months:

CURRENT PHYSIOLOGICAL APPRAISALS

Resting heart rate _____ (beats per minute)
Blood pressure _____ (mm HG.)
Blood Chemistry Cholesterol TC _____ LDL _____ HDL _____

Blood Glucose _____ mg of glucose/100 ml.

HABITUAL LIFESTYLE PATTERNS

1. Has your physician ever advised you against exercise? Yes or No If yes, why?

2. Are you presently receiving physical therapy? Yes or No.

3. Do you smoke? Yes or no
Have you ever smoked? Yes or No If so, when did you quit? _____
How much do you smoke? _____ Cigarettes or cigars? _____

4. Present amount of physical activity
_____ Very active (5 or more times per week)
_____ Active (3-5 times per week)
_____ Limited (1-3 times per week)
_____ Very limited (once in a while)
_____ None

5. Do you drink alcohol? Yes or No
Number of drinks per day _____ Type _____

6. How would you rate the stress level of your job?
_____ Little _____ Moderate _____ Stressful

7. Have you had any injuries, orthopedic concerns, pain or discomfort in or around the joints (includes neck, back, shoulders, knees, hips, ankles, etc.)

8. Can you walk three miles briskly without fatigue? Yes or No

9. Can you jog 3 miles continuously at a moderate pace without discomfort? Yes or No

10. Are you currently on any kind of diet? _____

11. Are you involved in an exercise program at the present time? Yes or No
If yes, please describe the program: _____

12. Have you worked with a personal trainer in the past? _____

13. Any additional information or comments before beginning your exercise program? _____
