Calvary Community Wellness Center
Health History Questionnaire

Name:_____Employer: _____
Home Address: _____ City: _____ ST: _____ Zip:_____
Home Phone: (_____) _____ Work Phone (_____) _____
Gender: Male or Female **Birth Date:** _____ / _____ / _____
Doctors Name: _____ **Doctors Phone**: _____
Doctors Address: _____ **Doctors Fax**: _____

Regular physical activity is safe for most people. However, some individuals should check with their doctor before they start an exercise program. To help us determine if you should consult with your doctor before starting an exercise program at Wellness Center, please read carefully and honestly answer the following questions. All information will be kept confidential by Wellness Center staff.

Please circle YES or NO.

YES NO 1. Do you have a heart condition?
YES NO 2. Have you ever experienced a stroke?
YES NO 3. Do you currently smoke?
YES NO 4. Has a physician ever told you or are you aware that you have high blood pressure?
YES NO 5. Has a physician ever told you or are you aware that you have high cholesterol?
YES NO 6. Has anyone in your immediate family (parents, brothers, sisters) had a heart attack, stroke or cardiovascular disease before the age of 55?
YES NO 7. Do you have diabetes?
YES NO 8. Do you consider yourself obese?
YES NO 9. Do you consider yourself to have an inactive lifestyle?

YES NO 10. Do you have epilepsy?
YES NO 11. Do you have emphysema?
YES NO 12. Do you have arthritis?
YES NO 13. Do you feel pain in your chest when you engage in physical activity?
YES NO 14. Do you feel pain in your chest when you are NOT engaged in physical activity?
YES NO 15. Have you ever had unusual shortness of breath at rest or with mild exertion?
YES NO 16. Do you ever suffer from dizziness or fainting spells?
YES NO 17. Are you a male over 44 years of age?
YES NO 18. Are you a female over 54 years of age?

YES NO 19. Are you currently taking medications?
Please list meds and purpose: _____
_____
YES NO 20. Are you pregnant?
Height _____ Weight _____ Age _____

Is there anything else regarding your health history that we should be aware of before you begin an exercise program? _____
_____
_____

TURN OVER

What are your health and fitness goals? Check all that apply:

_____ Achieve balance in life _____ Control blood pressure _____ Control cholesterol
_____ Exercise regularly _____ Feel better overall _____ Improve cardiovascular fitness
_____ Improve flexibility _____ Improve muscle tone _____ Improve nutritional habits
_____ Improve productivity _____ Increase muscle mass _____ Increase Strength and endurance
_____ Injury rehab _____ Other _____ Reduce body fat
_____ Reduce stress _____ Reduce back pain _____ Stop smoking

To the best of my knowledge I have completed this form honestly and completely. I understand it is my responsibility to inform the Wellness Center staff of any changes in my health status that may affect my participation in exercise activities.

_____ _____

Participant Signature Date

Staff Use Only:

Cleared to Exercise _____ Not cleared to Exercise _____Reason: _____
Number of Risk Factors Questions 1 – 9: _____
Number of Signs / Symptoms Questions 10 – 18,20: _____
Age: _____ Pregnant: YES or NO Physicians Release Requested: YES or NO
Date Sent: _____ / _____/_____

Staff Signature: _____