HEALTH HISTORY QUESTIONNAIRE

General Information
Last ____________________________  First _______________________  MI____
Phone ____________________________  Email ____________________________
Date of Birth ________________________  Height _______  Weight _______
Age ____________  Gender  ☐  Male  ☐  Female  ☐  Transgender/Non-Binary

Medical Care Information
Physician Name ________________________  Phone ____________________________
Clinic Name _____________________________  Fax ____________________________

Emergency Contact Information
Name ________________________________  Phone ____________________________

Please check all true statements about you that apply.

Experiencing these Symptoms
☐  chest discomfort with exertion
☐  unreasonable breathlessness
☐  dizziness, fainting or blackouts
☐  ankle swelling
☐  unpleasant awareness of a forceful, rapid or irregular heart rate
☐  burning or cramping sensation in your lower legs when walking short distances
☐  None of the above

Current Physical Activity
Planned, structured physical activity at moderate intensity (noticeable increase in breathing and heart rate) in the last 3 months
Days per week
☐  0  ☐  1-2  ☐  3-5  ☐  6-7
Duration (in minutes)
☐  <10  ☐  11-30  ☐  31-60  ☐  60+
**Medical Conditions** – You have had:
- □ a heart attack
- □ heart surgery, cardiac catheterization or coronary angioplasty
- □ pacemaker/implantable cardiac defibrillator/rhythm disturbance
- □ heart valve disease
- □ heart failure
- □ heart transplantation
- □ congenital heart disease
- □ diabetes
- □ renal disease
- □ stroke or cerebrovascular disease
- □ peripheral vascular disease
- □ None of the above

**Health Issues**
- □ asthma, bronchitis, pneumonia, emphysema or other lung disease
- □ arthritis
- □ parkinson's
- □ MS
- □ balance challenges or falls
- □ currently pregnant or less than six weeks post-partum
- □ cancer, diagnosed ≤ 12 months  Yes  No
- □ musculoskeletal problems limiting your physical activity _______________________________
- □ recent surgeries ________________________________________________________________
- □ None of the above

**Stress**
Amount of stress you experience on a daily basis
- □ no stress, easy going
- □ frequent moderate stress
- □ occasional stress
- □ constant high stress

**Care Giver needed**  □ Yes  □ No

**Mobility Limitations** ________________________________

Currenty experiencing musculoskeletal or health issues not listed above
______________________________________________________________

I understand that completion of the health history questionnaire and risk stratification is required prior to starting my exercise program. I certify that all of the information I have provided on this form is true and accurate. I will notify OHSU march wellness & fitness center of any changes in my health status.

______________________________  ________________________________
Member Signature  Date

Comments __________________________________________________________

ACSM Risk Stratification PA Needed  □ Yes  □ No  Staff Initials _____________________