MCA Health & Fitness Center

Medical History Questionnaire

Name: ____
Last First Middle Initial

Date of Birth: _______________ Age: ______________ Sex: M F

Weight: ____________________ Height: ____________ Resting HR: ________________

Physician: ____________________________________

Cardiologist: __________________________________

Personal History and Risk Factors

Are you a diabetic? Yes____ No____

How is your diabetes controlled? Diet____ Pills____ Insulin____

Do you have epilepsy? Yes____ No____

Do you ever lose consciousness or lose control of your balance due to chronic diseases?

Yes____ No____

Have you had any of the following:

Heart Attack? Yes____ No____ When______________________

Stroke? Yes____ No____ When______________________

Heart or Blood Vessel surgery? Yes____ No____ When______________________

Angioplasty? Yes____ No____ When______________________

Heart Cath? Yes____ No____ When______________________

Do you have a heart pacemaker? Yes____ No____

Do you ever feel pain in your chest while engaging in physical activity? Yes____ No____

In the past month, have you ever had chest pain when you were not engaging in physical activity? Yes____ No____

Do you have high blood pressure? Yes____ No____ When______________________

Are you on BP Medicine? Yes____ No____ When______________________

Are you now or have you ever been a cigarette smoker? Yes____ No____

Packs per day? ________ Years smoked? ________ If you quit, when? ________

Do you have high cholesterol? Yes____ No____ Most recent reading?________

Are you currently being treated for or have you ever had a bone or joint problem that restricted you from engaging in physical activity? Yes____ No____

Are you currently exercising less than one hour per week? Yes____ No____

Have you ever participated in Cardiac Rehab Phase II program? Yes____ No____

Family History

Has anyone in your immediate family (parents, brothers, sisters) had a heart attack, stroke, diabetes or cardiovascular disease before the age of 55? Yes____ No____

Medical History

List operations, major illnesses and hospitalizations:

____
____
____

Allergies:

____
____
____

Medications (please list name and purpose):

____
____
____
____

We believe that it is in your best interest to discuss becoming physically active with your doctor, especially if you are a man 45 years or older or a woman 55 years or older. Please choose one of the following:

____I have/will discuss becoming physically active with my doctor.

____I decline to discuss becoming physically active with my doctor.