

UMF FRC General Health History

Name _____ D.O.B. _____ Age _____
Date _____ Phone# daytime _____ evening _____
e-mail _____
Address: _____

Do you smoke? _____ How long? _____ How much daily _____?
If you smoke, do you wish to quit? _____
Have you smoked in the past? How long? _____ How much daily _____?
Quit when? _____

Personal Health History

Diabetes	Yes	No
Heart disease or heart attack	Yes	No
High blood pressure	Yes	No
Stroke	Yes	No
Chest pains, or chest pains on exertion	Yes	No
Shortness of breath at rest	Yes	No
Shortness of breath after climbing 2 flights stairs	Yes	Yes No
Daily coughing	Yes	No
High cholesterol	Yes	No
Asthma or other respiratory problem	Yes	No
Arthritis or fibromyalgia	Yes	No

Are you currently taking any **medications?** _____ If so, please list:

Medication _____	Reason _____
Medication _____	Reason _____
Medication _____	Reason _____
Medication _____	Reason _____
Medication _____	Reason _____

Please list any injuries to bones, joints, muscles, with dates of injury and effects on exercise.

Please list any surgeries that may be currently affecting your ability to exercise:

Continued on other side->

Do you have any back pain or discomfort?_____Please explain.

Family health history (parents and siblings)

Diabetes	Yes	No	
Heart disease or heart attack		Yes	No
If yes, at what age_____			
High blood pressure	Yes	No	
Stroke	Yes	No	

Please answer the following questions:

What is your occupation?_____

How physically active does it require you to be? (circle one)

Not at all A little Moderate Very active Intensely active

Rate your leisure time activity in the same way. (circle one)

Not at all A little Moderate Very active Intensely active

How would you describe your present fitness level?

Poor Fair Average Good Excellent