ELMWOOD FITNESS CENTER
A division of Ochsner Clinic Foundation

Appt. Yes____ No____ Later____
Date:_____
Time:_____
FC:_____

Medical Health History Questionnaire

This questionnaire is designed to determine any health risk factors and/or conditions prior to you beginning a fitness program. This may indicate the need for a physician's consent prior to the start of your program. Additionally, the information that you provide will enable us to better understand you and your health and fitness needs. The information you provide is maintained with strict confidentiality.

First Name: _____ M.I._____ Last:_____ Date: _____
Home Phone: _____ Work Phone: _____Cell Phone: _____
Date of Birth: _____ Gender: _____ Email:_____
Physician: _____ Physician's Phone:_____
Physician's Office: _____

Please circle the appropriate response and provide additional information when indicated.

I. Signs and Symptoms: Have you ever experienced any of the following:

1. Pain, discomfort, tightness or numbness in the chest, neck, jaw or arms. _____Y N
2. Shortness of breath at rest or with mild exertion. _____Y N
3. Dizziness or fainting._____Y N
4. Difficult, labored or painful breathing during the day or at night. _____Y N
5. Ankle swelling. _____Y N
6. Rapid pulse or heart rate. _____Y N
7. Intermittent cramping. _____Y N
8. Known heart murmur. _____Y N
9. Unusual shortness of breath or fatigue with usual activities. _____ Y N

If you answered **Yes** to any of the above:
How often do you experience the symptom? _____
Have you ever discussed the symptom with a doctor? _____
Explain the symptom in more detail. _____
_____

II. Major Risk Factors

1. Are you a male and age 45 years or older? _____Y N
2. Are you a female age 55 years or older, or have you experienced premature menopause without estrogen replacement therapy?_____Y N
3. Has your father or brother experienced a heart attack before age 55?_____Y N
4. Has your mother or sister experienced a heart attack before age 65? _____Y N
5. Do you smoke? _____Y N
6. Has your doctor ever told you that you have or might have high blood pressure/hypertension? _____Y N
7. Do you have high cholesterol? _____Y N
   Total cholesterol level (if known): _____HDL level: _____ Date tested: _____
8. Do you have diabetes? _____Y N
   If yes, do you take insulin? Y N Year diagnosed? _____
9. Do you have a sedentary lifestyle?_____Y N

(i.e. do you sit most of the day with no regular physical activity)

III. Medical Diagnoses

Have you ever had any of the following? Circle all that apply:

heart attack angioplasty heart surgery coronary artery disease

heart murmur heart clicks stroke Angina

Please provide details regarding any condition that you identified above: _____

_____

_____

_____

Have you ever had any of the following? Circle all that apply:

asthma emphysema bronchitis cancer diabetes anemia

Please provide details regarding any condition that you identified above: _____

_____

_____

Please identify any health condition not listed above that may affect your ability to engage in physical activity:_

_____

_____

_____

IV. General

1. Are you pregnant? _____ Y N
2. Do you have osteoporosis? _____ Y N
3. Do you have arthritis or any bone or joint problem? _____ Y N
   If yes, please explain: _____
   _____
   _____

4. Do you currently exercise? _____ Y N
   If yes, how long have you been exercising? _____
   What do you do and how often? _____
   _____

5. Are you taking any medications (prescribed and/or over-the-counter), vitamins or supplements? ___ Y N
   Please list them and their dosage(s) _____
   _____
   _____

My signature certifies that all of the above is true, to the best of my knowledge.

Signature:_____ Date:_____

Risk stratified by:_____ Low_____ Moderate_____ High_____