Health History

Name

Employee ID #

Date of Birth

Emergency Contact's Name

Male Female

Address

Phone Relationship

City State ZIP

Physician's Name

Department Phone

Phone Date Last Physical

Section A

Do you currently have any of the following health conditions?

Diagnosed High Blood Pressure (12) (or systolic BP>140 or diastolic > 90 mmHG on at least 2 separate checks) Y N

Diagnosed Hyperlipidemia/ Abnormal Blood Lipids (or cholesterol>240 mg/dl)(32) Y N

Smoking Habit (within past 6 months)(49) Y N

Diabetes(7) Y N

Family History of Heart Disease (9) (parents or siblings before age 55) Y N

Section B

Do you have a past or recent history of any of the following conditions?

Heart/Vascular (please specify) Y N

- heart disease (11), heart attack(10), angina(1)
- coronary angioplasty/cardiact surgery(6)
- rapid heartbeats/palpitations(31)
- heart murmurs or unusual cardiac findings(20)
- peripheral vascular disease(15)
- stroke(19)
- other

Metabolic Disease (please specify) Y N

- kidney disease(33)
- thyroid or other metabolic disorders (33)

Respiratory Problems (please specify) Y N

- asthma(33)
- chronic bronchitis(37)
- emphysema or COPD(37)

Section C

Do you currently have any of the following symptoms of conditions?

Chest Discomfort (at rest or with exertion) (5)	○ Y ○ N
Fainting/Lightheadedness (30) (unexplained or unusual, especially with exertion)	○ Y ○ N
Fatigue (unexplained or unusual) (36)	○ Y ○ N
Major Surgery/Hospitalization (45) (within the past 6 months)	○ Y ○ N
Shortness of Breath (unexplained or unusual, especially with exertion)(18)	○ Y ○ N
Ankle Swelling (50)	○ Y ○ N

If any items in the sections above are marked yes, the Medical Consulation form, must be completed by a physician prior to your fitness test.

Please check if you have any of the following conditions. These conditions do not require medical consultation.

- ☐ Anemia (severe <10 GM/dl) (35)
- ☐ Chronic Back Problems (25)
- ☐ Arthritis (25)
- ☐ Orthopedic Problems

Please specify body region if you have arthritis or orthopedic problems.

What other medical conditions or physical limitations should be considered prior to your participation in an exercise program?

Please list any drugs or medications you are taking which you think may impact your exercise performance or safety.

Drugs

Reason

Are you allergic to any medications? ○ Y ○ N

If Yes, please specify

(Last updated 4/15/09 by HR)