Health History Questionnaire

NAME_____Date of Birth_____Age_____

Address:_____City_____State_____

Phone_____ Sex: Male Female Height_____Weight_____

Primary Physician_____ City, State_____ Phone_____

Emergency Contact Person:_____Relationship:_____

Emergency Contact Phone: (H)_____(W)_____(C)_____

DO YOU NOW, OR HAVE YOU EVER HAD: (Please answer YES or NO)

_____History of heart disease (yourself, father, mother, siblings)

_____High Blood Pressure

____High Cholesterol

____Diabetes (insulin or non-insulin dependent)

_____Stroke

_____Pulmonary disease (asthma, emphysema, chronic bronchitis)

_____Surgery within the last 2 years: list type of surgery and date:_____

Yes No Do you smoke?

Yes No Do you have any other chronic illness (i.e. anxiety, seizure disorder, epilepsy, multiple sclerosis, Alzheimer's, dementia, hearing loss, etc.)? If so, what?_____

Yes No Have you had advice from a physician NOT to exercise? If so, why?_____

Yes No Do you have muscle, joint, or back problems that become worse with physical activity?

If so, what?_____

Yes No Females: Are you now pregnant or have you been pregnant within the past three months?

List medications you are taking and your reason for taking them:_____

_____

_____

I UNDERSTAND THAT I WILL BE EXERCISING AND/OR SWIMMING AT MY OWN RISK AT THE OTTAWA COUNTY WELLNESS CENTER. SIGNED:_____DATE:_____

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