# Health History Questionnaire
## The Endorphasm Foundation

Last name_____First name_____

Home phone_____Work phone_____

E-mail address_____

Home address_____

In case of emergency contact_____

Emergency contact phone_____

Personal physician_____phone_____

Date of birth_____age_____

The testing and evaluation proBCRBSs provides information on your current level of fitness, and for the development of an individual exercise program. The fitness assessment emphasizes cardiovascular and muscular fitness as well as flexibility, range of motion, core strength, and balance. In order to get a complete and appropriate individual assessment, it is imperative that you fill out this form completely and that you don't leave out any information that could influence your individual program.

**Family history – check if any of your immediate family has had:**

Heart Disease ( )Mom ( )Dad ( )Grandfather ( )Grandmother ( )Brother/sister

Stroke ( )Mom ( )Dad ( )Grandfather ( )Grandmother ( )Brother/sister

Diabetes ( )Mom ( )Dad ( )Grandfather ( )Grandmother ( )Brother/sister

High blood pressure ( )Mom ( )Dad ( )Grandfather ( )Grandmother ( )Brother/sister

High cholesterol ( )Mom ( )Dad ( )Grandfather ( )Grandmother ( )Brother/sister

Other conditions/comments:_____

_____

If there was a documented case of heart disease, please check the age category when they first knew.

( )Under 50 years of age

( )Between 50-65 years of age
( )Over 65 years of age

Have any relatives died suddenly, without prior warning or knowledge of heart disease?

( )Yes ( )No If yes, who?_____Age at time of death?_____

**Personal history – check if you have had:**

AIDS( ) Anemia( ) Arthritis( ) Asthma( ) Bronchitis or emphysema( )

**Cancer( )**_____

If so, what kind?_____ Surgery (type and date)_____

_____

Treatment (type and date)_____

Diabetes( ) Epilepsy( ) Gout( ) Heart disease( ) Heart murmer, skipped, or rapid beats( )

High blood pressure( ) High cholesterol( ) Kidney disease( ) Lung disease( )

Phlebitis( ) Rheumatic fever( ) Stroke( ) Thyroid problems( )

**Orthopedic injuries or chronic pain:**

Neck( ) L shoulder( ) R shoulder( ) Cervical spine( ) Thoracic spine( ) Lumbar spine( )

L elbow( ) R elbow( ) L wrist( ) R wrist( ) L hip( ) R hip( ) L knee( ) R knee( )

L ankle( ) R ankle( ) other( )

Please explain any of the above that you have checked_____

_____

_____

Other conditions/comments_____

_____

**Medications**

Are you currently taking any prescription medications? ( )Yes ( )No If yes, what and how much?

_____

_____

Are you currently taking any over-the-counter medications or vitamins? ( )Yes ( )No If yes, what and how much?_____

_____

**Health habits**

Smoking history:

Do you smoke? ( )Yes ( )Quit ( )Never

What do/did you smoke? ( )Cigarettes ( )Cigars ( )Pipe

How much did/do you smoke a day?_____

How long have you been smoking?_____If quit, when?_____

**Exercise habits**

Do you engage in physical activity? ( )Yes ( )No

What kind?_____

How hard? ( )Light ( )Moderate ( )Hard How often?_____

Did your past exercise habits differ from what you are doing now? ( )Yes ( )No

What kind of exercise did you do in the past?_____

_____

How hard? ( )Light ( )Moderate ( )Hard How often?_____

Is your occupation ( )Sedentary ( )Active ( )Heavy work
Explain:_____

Do you experience discomfort, shortness of breath, or pain with exercise? ( )Yes ( )No

If yes, what type of exercise/symptoms?_____

_____

**Nutritional behavior**

Do you consider yourself overweight? ( )Yes ( )No

If yes, how long have you been overweight?_____

How many meals do you typically eat per day?_____
How often do you eat outside the home?_____per week

How much of the following do you consume?

_____cups of caffeinated coffee or tea per day

_____glasses of caffeinated soda per day

_____glasses of beer per day (12oz. = 1 unit)

_____glasses of wine per day (4 oz. = 1 unit)

_____glasses of liquor per day (11/2 oz. = 1 unit)

_____units of alcohol per week (see above for unit equivalent)

**Stress**

Do you consider your day stressful? ( )Yes ( )No

What is the nature of your stress?_____

How many hours do you sleep a night?_____Is your sleep sound? ( )Yes ( )No

Do you practice any form of meditation? ( )Yes ( )No If so, what?_____

_____

## What is your preferred training schedule? (days/hours of availability)

_____