

HEALTH HISTORY QUESTIONNAIRE

Name: _____ e-mail: _____
Home phone: _____ Work or Cell: _____
Emergency Contact Name: _____ Phone: _____

MEDICAL HISTORY

I have or have had a history of: (check any that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Heat Stroke/Exhaustion | <input type="checkbox"/> Heart dysfunction |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Diabetes/hypoglycemia | <input type="checkbox"/> Concussions |
| <input type="checkbox"/> Cancer/tumors | <input type="checkbox"/> Ulcers/Gastric disorders | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Embolism | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Respiratory disorders |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> A fixed pacemaker | <input type="checkbox"/> Aneurysm |
| <input type="checkbox"/> Nocturnal dyspnea | <input type="checkbox"/> Shortness of breath at rest | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Ankle edema | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Poor circulation |

Has your physician ever advised you against exercise? Yes No
If yes, when? _____

Are you presently receiving physical therapy? Yes No
Might we contact your physical therapist? Yes No
Name/contact info: _____

Are you presently under a doctor's care? Yes No
Might we contact your doctor? Yes No
Name/contact info: _____

Do you smoke or have you recently quit smoking in the last six months? Yes No

Do you have a family history of myocardial infarction (heart attack)?
Before the age of 55 for males- Yes No
Before the age of 65 for females- Yes No

Do you have a cholesterol level over 200mg/dl or HDL under 32mg/dl? Yes No

Do you have any conditions/past injuries which may limit your ability to exercise? Yes No

Do you habitually consume over 3-4 cups of coffee/cans of soda per day? Yes No

Check if you currently take any of the following **MEDICATIONS**:

- | | | |
|---|---|---|
| <input type="checkbox"/> Steroids (cortisone) | <input type="checkbox"/> Anti-inflammatory | <input type="checkbox"/> Pain killers |
| <input type="checkbox"/> Muscle relaxants | <input type="checkbox"/> Anti-coagulants (blood thinners) | <input type="checkbox"/> Insulin (diabetes) |
| <input type="checkbox"/> Blood pressure medications | <input type="checkbox"/> Heart medication | <input type="checkbox"/> Other _____ |

Have you ever participated in a fitness program? Yes No
If yes, when/where? _____

How would you rate your present fitness level?
 Very fit Fit Average Below average Un-fit

List previous **SURGERIES**:

| | | |
|------------------|-------------|---------------|
| Procedure: _____ | Date: _____ | Doctor: _____ |
| Procedure: _____ | Date: _____ | Doctor: _____ |
| Procedure: _____ | Date: _____ | Doctor: _____ |
| Procedure: _____ | Date: _____ | Doctor: _____ |

| |
|----------------------------|
| ORTHOPEDIC HISTORY: |
|----------------------------|

Do you have or have you in the past had complications with:

NECK:

- Burners/Stingers
 Fractures/Sprains/Strains
 Other _____

SPINE/BACK:

- Fractures
 Disc Ruptures
 Pain/Spasm
 Other _____

LOWER LEG:

- Shin Splints
 Achilles Pain
 Fractures
 Other _____

SHOULDER

- Fractures/Sprains
 Separations
 Dislocations
 Other _____

HAND/WRIST/FINGERS:

- Fractures/Dislocations
 Sprains
 Numbness/Pain
 Other _____

ANKLE:

- Sprains
 Dislocations
 Fractures
 Other _____

ARM:

- Fractures
 Numbness/Pain
 Other _____

PELVIS/HIP:

- Sprains/Contusions
 Fractures/Dislocations
 Other _____

FEET/TOES:

- Fractures/Dislocations
 Sprains
 Other _____

ELBOW:

- Fractures
 Sprains
 Dislocations
 Inflammation
 Other _____

THIGH:

- Muscle Sprains
 Muscle Contusions
 Fractures
 Other _____

KNEE:

- Sprains
 Torn Ligaments/Cartilage
 Fractures/Dislocations
 Giving way/Locking
 Other _____

I have answered the preceding questions and have completed the *Health History Questionnaire* to the best of my ability. I have understood all the questions asked of me and have been given the opportunity to have any of my concerns clarified to my satisfaction. I further understand that thorough and honest responses to these questions are essential to my safety and prudent recommendations from the provider.

Parent Signature _____

Date _____