Medical Health History Questionnaire

This form is not a substitute for a thorough physical examination, assessment, and/or diagnosis by your physician. It is designed to identify and understand potential issues that may arise due to an increase in physical activity. The Auburn University Rec and Wellness team strongly recommends that each client undergo a medical examination before beginning any exercise program. All information provided on this form is personal and confidential and will not be released to anyone except your referring physician without your written consent. The information you provide will enable us to better understand you and your health and fitness habits.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ @auburn.edu Phone Number: _____

Date of Birth: _____ Age: _____ Gender: _____ Height: _____ Weight: _____

Auburn Affiliation: ☐ Faculty/Staff ☐ Student ☐ Fr ☐ So ☐ Jr ☐ Sr ☐ Grad ☐ Retiree ☐ Spouse/Partner

Physicians Name: _____ Phone Number: _____

Emergency contact: _____ Relationship: _____

Home phone: _____ Cell Phone: _____

I. Personal Fitness Goals & Exercise History

1. Please indicate your personal health and fitness goals: (check all that apply)

☐ Reduce Body Fat & Lose Weight ☐ Weight Gain ☐ Better Balance & Mobility

☐ Increased Confidence & Energy ☐ Improve Stamina & Flexibility ☐ Improve Nutrition

☐ Build Lean Muscle Mass ☐ Muscular Strength ☐ Improve Cardiovascular Fitness

☐ General Health & Fitness ☐ Reduce Blood Pressure/Cholesterol ☐ Reshape Body

☐ Enhance Work, recreation & Sports Performance Other: ☐ _____

Please tell us more about your specific short and long term goals for exercise, health, and fitness:

2. Exercise history	Yes	No
Do you currently exercise? If yes, how many times per week? _____	☐	☐
If no, have you exercised in the past?	☐	☐
Have you ever worked with a fitness professional before?	☐	☐
If you currently exercise, what exercise activities does your workout program include?	☐	☐

II. Signs and symptoms

3. Have you ever experienced any of the following: (check all that apply)

- ☐ Pain, discomfort, tightness or numbness in the chest, neck, jaw or arms
- ☐ Shortness of breath at rest or with mild exertion
- ☐ Difficult, labored or painful breathing during the day or night
- ☐ Unusual shortness of breath or fatigue with usual activities
- ☐ Heart murmur and/or palpitations
- ☐ Severe headaches
- ☐ Dizziness or Fainting
- ☐ Ankle Swelling
- ☐ Rapid pulse or heart rate
- ☐ Claudication (Cramping)
- ☐ Back Pain
- ☐ Orthopedic problems

If you checked any of the above conditions, you must explain below:

III. Medical diagnoses

4. Have you ever been diagnosed with, or suffered from: (check all that apply)

- ☐ Heart attack/heart disease
- ☐ Coronary bypass
- ☐ Stroke
- ☐ Aneurysm
- ☐ Angioplasty
- ☐ Other Cardiac Surgery
- ☐ Pacemaker
- ☐ Embolism
- ☐ Angina Pectoris
- ☐ Phlebitis

If you checked any of the above conditions, you must have **medical clearance** prior to exercising. Please give details:

5. Have you ever been diagnosed with, or do you have any of the following: (check all that apply)

- ☐ Chronic bronchitis
- ☐ Diabetes
- ☐ Osteopenia
- ☐ Asthma
- ☐ Thyroid problems
- ☐ Emotional disorders
- ☐ Cancer
- ☐ Peripheral vascular disease
- ☐ Osteoporosis
- ☐ Emphysema
- ☐ Hypertension (>140/90 mmhg)
- ☐ High cholesterol (>200 mg/dl)
- ☐ Eating disorders
- ☐ Swelling of joints

If you checked any of the above conditions, please explain below:

IV. Major risk factors

6. Please answer all of the following questions:	Yes	No	Unsure
Are you a male over the age of 45 or	☐	☐	☐
Female over the age of 55 who has had a hysterectomy or is postmenopausal?	☐	☐	☐
Has your father or brother experienced a heart attack before age of 55?	☐	☐	☐
Has your mother or sister experience a heart attack before age of 65?	☐	☐	☐
Do you have impaired fasting glucose (diabetes)?	☐	☐	☐
If yes, do you take insulin? What year was the diagnosis? _____			
Do you have high cholesterol (>200ml/dl)?	☐	☐	☐
Has your doctor ever told you that you might have high blood pressure?	☐	☐	☐
Do you currently smoke or have you smoked in the past 6 months?	☐	☐	☐
Do you have a sedentary lifestyle?	☐	☐	☐

If you are a man over the age of 45 or a woman over the age of 55 or if you answered "yes" to two (2) or more of the above major risk factors, it is recommended that you receive a **physician's clearance** *before beginning your exercise program.*

V. General

7. Please tell us more about you:	Yes	No
Are you currently pregnant?	☐	☐
Are you currently on a special diet?	☐	☐
Have you had a recent surgery in the past 12 months?	☐	☐
Do you have seasonal allergies and/or hay fever?	☐	☐

Do you take ergogenic aids, diet supplements, vitamins, minerals, etc.? ☐ ☐

8. Please list any medications you are currently taking including but not limited to prescriptions, allergy medications, Do you have allergies to any foods or medications?

Medication (supplement): _____ Reason: _____ Dosage: _____

Medication (supplement): _____ Reason: _____ Dosage: _____

Medication (supplement): _____ Reason: _____ Dosage: _____

Medication (supplement): _____ Reason: _____ Dosage: _____

I understand this medical health history questionnaire has been provided for the purpose of helping me better understand any potential risks associated with a workout program. I also understand I should share this information with my physician and seek his or her approval prior to beginning an exercise program. I understand the information I have provided will be maintained in my personal file for use in case of a medical emergency. My signature signifies that all of the above is true, to the best of my knowledge. Any information left unanswered was done so intentionally. If any of the above information changes, I agree to submit these changes in writing to the coordinator, personal training to update my personal training file.

Participant signature: _____ Date: _____

Fitness staff signature: _____ Date: _____

Staff Use Only Classification: ☐ Low Risk ☐ Moderate Risk ☐ High Risk

Comments: _____

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