Union University
Department of Wellness Services
Health History Questionnaire

Personal

Name: ______________________________________________  
  Last  First  MI

Home Address: ________________________________
  __________________________________________

Email Address: _____________________________

Home Phone: ______________________________

Medical Information

Physician: ________________  Emergency Contact: ________________
Address: ____________________  Phone Number: __________________
  __________________________________________  Relationship: __________
Phone: ____________________

Physical Activity Readiness Questionnaire

YES    NO

___    ___  1. Has your doctor ever said that you have a heart condition AND that you should only do physical activity recommended by a doctor?

___    ___  2. Do you feel pain in your chest when you do physical activity?

___    ___  3. In the past month, have you had chest pain when you were not doing physical activity?

___    ___  4. Do you lose your balance because of dizziness or do you ever lose consciousness?

___    ___  5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?

___    ___  6. Is your doctor currently prescribing drugs for your blood pressure or heart condition?

___    ___  7. Do you know of any other reason why you should limit physical activity?
List any allergies that you may have:

____________________________________________________________________
____________________________________________________________________

Medical History

1. Date of Birth: ___/___/___

2. Date of last physical exam: ___/___/___

3. Please circle any of the following for which you have been diagnosed or treated by a health physician:

   - Diabetes
   - Rheumatoid Arthritis
   - Anemia
   - Asthma
   - Emphysema
   - Bleeding Trait
   - Obesity
   - Emphysema
   - Stroke
   - Concussion
   - Heart Problem
   - High Blood Pressure
   - Kidney Problem
   - Neck Strain
   - Back Strain

4. List all medication taken within the past 6 months:

   ___________________________________________________________________
   ___________________________________________________________________

5. Any of these health symptoms that occur frequently can indicate a need for medical attention. Circle the number indicating how often you have each of the following:

   5- very often  4-fairly often  3-sometimes  2-infrequently  1-almost never  0-never

   a. cough up blood  b. abdominal pain  c. low back pain
   0 1 2 3 4 5 0 1 2 3 4 5 0 1 2 3 4 5

d. leg pain  e. arm or shoulder pain  f. chest pain
   0 1 2 3 4 5 0 1 2 3 4 5 0 1 2 3 4 5

g. swollen joints  h. feel faint  i. dizziness
   0 1 2 3 4 5 0 1 2 3 4 5 0 1 2 3 4 5

   j. breathless with slight exertion
   0 1 2 3 4 5

6. Do you smoke now? Yes  No

7. Do you exercise regularly? Yes  No

8. List everything not already included on this questionnaire that might cause you problems in a fitness test or fitness program:

   _______________________________________________________________________
   _______________________________________________________________________