



1609 N. Coalter Street
Staunton, VA 24401
540-294-0221

Medical/Exercise History Questionnaire

Part 1-General Information

1. Name: _____
2. Home Address: _____
City: _____ State: _____ Zip: _____
3. Home Phone: _____ Business Phone: _____ Cell Phone: _____
4. Date of Birth: _____ Age: _____ Sex: _____ Male _____ Female
5. Emergency Contact Name: _____
6. Emergency Contact Number(s): _____
7. Personal Physician: _____ Phone Number: _____
8. Number Hours Worked Per Week: <20 20-40 41-60 Over 60
9. More than 25% of time spent on job (circle all that apply):
Sitting at desk Lifting or carrying loads Standing Walking Driving

Part 2-Medical History

10. Date of last medical exam: _____
11. Circle any surgeries that you have had and describe briefly:
Back Heart Kidney Lung Joint Neck Hernia Ears Eyes
Other: _____
Description: _____

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

Alcoholism	Diabetes	Anemia
Emphysema	Kidney problems	Mental illness
Arthritis	Epilepsy or seizures	Neck strain
Asthma	Eye problems	Obesity
Back Strain	Gout	Phlebitis
Bleeding trait	Hearing loss	Pregnancy*
Bronchitis, chronic	Heart disease	Stroke
Cancer	High blood pressure	Thyroid problem
Cirrhosis, liver	Hypoglycemia	Other: _____
Congenital defect	Hyperlipidemia	

Description: _____

*OR within 6 months post-partum

13. Any of these health symptoms that occurs frequently is the basis 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=Practically never

- | | |
|--------------------------------------|--|
| a. Cough up blood
1 2 3 4 5 | g. Swollen joints
1 2 3 4 5 |
| b. Abdominal pain
1 2 3 4 5 | h. Feel faint
1 2 3 4 5 |
| c. Lower back pain
1 2 3 4 5 | i. Dizziness
1 2 3 4 5 |
| d. Leg pain
1 2 3 4 5 | j. Breathless with slight exertion
1 2 3 4 5 |
| e. Arm or shoulder pain
1 2 3 4 5 | k. Palpitation or fast heart beat
1 2 3 4 5 |
| f. Chest pain
1 2 3 4 5 | l. Unusual fatigue w/ normal activity
1 2 3 4 5 |

14. Circle any who have passed away of a heart attack before age 50:

Father Mother Brother Sister Grandparent

15. Please list any medications that you are taking:

Medication Name	Dosage	Reason for Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PART 3-Health Related Behavior

16. Do you smoke? Yes No
17. Do you exercise regularly? Yes No
18. How many days per week do you accumulate 30 minutes of moderate activity?
0 1 2 3 4 5 6 7 days per week
19. How many days per week do you normally spend at least 20 minutes in vigorous exercise?
0 1 2 3 4 5 6 7 days per week
20. Can you walk 1 mile briskly without fatigue? Yes No
21. Can you jog 2 miles continuously at a moderate pace without discomfort? Yes No
22. Weight now: _____ lbs. One year ago: _____ lbs. 10 yrs. ago: _____

23. List everything not already included on this questionnaire that might cause problems

