

# HEALTH STATUS QUESTIONNAIRE

## SECTION ONE - GENERAL INFORMATION

1. Date \_\_\_\_\_
2. Name \_\_\_\_\_
3. Mailing Address \_\_\_\_\_ Phone (H) \_\_\_\_\_  
\_\_\_\_\_ Phone (W) \_\_\_\_\_  
Email \_\_\_\_\_
4. *EI* Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Physician Address \_\_\_\_\_ Fax \_\_\_\_\_  
\_\_\_\_\_
5. *EI* Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_
6. Gender (circle one): Female      Male *RF*
7. *RF* Date of birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
8. Height \_\_\_\_\_ Weight \_\_\_\_\_
9. Number of hours worked per week:    Less than 20      20-40      41-60 over 60
10. *SLA* More than 25% of the time at your job is spent (circle all that apply)  
                  Sitting at desk      Lifting loads      Standing      Walking      Driving

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## SECTION TWO - CURRENT MEDICAL INFORMATION

11. Date of last medical physical exam: \_\_\_\_\_
12. Circle all medicine taken of prescribed in last 6 months:  
          Blood thinner *MC*      Epilepsy medication *SEP*      Nitroglycerin *MC*  
          Diabetic *MC*      Heart rhythm medication *MC*      Other \_\_\_\_\_  
          Digitalis *MC*      High blood pressure medication *MC*  
          Diuretic *MC*      Insulin *MC*
13. Please list any orthopedic conditions. Include any injuries in the last six months  
\_\_\_\_\_

14. Any of these health symptoms that occur frequently (two or more times/month) requires medical attention. Please check any that apply.

- |                                       |   |
|---------------------------------------|---|
| a. ___ Cough up blood <i>MC</i>       | g. ___ Swollen joints <i>MC</i>                       |
| b. ___ Abdominal pain <i>MC</i>       | h. ___ Feel faint <i>MC</i>                           |
| c. ___ Low-back pain <i>MC</i>        | i. ___ Dizziness <i>MC</i>                            |
| d. ___ Leg Pain <i>MC</i>             | j. ___ Breathlessness with slight exertion <i>MC</i>  |
| e. ___ Arm or shoulder pain <i>MC</i> | k. ___ Palpitation or fast heart beat <i>MC</i>       |
| f. ___ Chest pain <i>RF MC</i>        | l. ___ Unusual fatigue with normal activity <i>MC</i> |
- Other \_\_\_\_\_

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### SECTION THREE - MEDICAL HISTORY

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

- |                                |                          |                                 |
|--------------------------------|--------------------------|---------------------------------|
| Alcoholism <i>SEP</i>          | Diabetes <i>SEP</i>      | Kidney problem <i>MC</i>        |
| Anemia, sickle cell <i>SEP</i> | Emphysema <i>SEP</i>     | Mental illness <i>SEP</i>       |
| Anemia, other <i>SEP</i>       | Epilepsy <i>SEP</i>      | Neck strain <i>SLA</i>          |
| Asthma <i>SEP</i>              | Eye problems <i>SLA</i>  | Obesity <i>RF</i>               |
| Back strain <i>SLA</i>         | Gout <i>SLA</i>          | Phlebitis <i>MC</i>             |
| Bleeding trait <i>SEP</i>      | Hearing loss <i>SLA</i>  | Rheumatoid arthritis <i>SLA</i> |
| Bronchitis, chronic <i>SEP</i> | Heart problems <i>MC</i> | Stress <i>RF</i>                |
| Stroke <i>MC</i>               | Cancer <i>SEP</i>        | High blood pressure <i>MC</i>   |
| Thyroid problem <i>SEP</i>     | Cirrhosis <i>MC</i>      | HIV <i>SEP</i>                  |
| Ulcer <i>SEP</i>               | Concussion <i>MC</i>     | Hypoglycemia <i>SEP</i>         |
| Congenital defect <i>SEP</i>   | Hyperlipidemia <i>RF</i> | Other _____                     |

16. Circle any operations that you have had:

- |                 |                   |                   |                 |                  |                 |
|-----------------|-------------------|-------------------|-----------------|------------------|-----------------|
| Back <i>SLA</i> | Heart <i>MC</i>   | Kidney <i>SLA</i> | Eyes <i>SLA</i> | Joint <i>SLA</i> | Neck <i>SLA</i> |
| Ears <i>SLA</i> | Hernia <i>SLA</i> | Lung <i>SLA</i>   | Other _____     |                  |                 |

17. *RF* Circle any who died of heart attack before age 55:

Father                  Brother                  Son

18. *RF* Circle any who died of heart attack before age 65:

Mother                  Sister                  Daughter



29. How often do you experience “negative” stress from each of the following:

	Always	Usually	Frequently	Rarely	Never
Work:	_____	_____	_____	_____	_____
Home or family :	_____	_____	_____	_____	_____
Financial pressure:	_____	_____	_____	_____	_____
Social pressure:	_____	_____	_____	_____	_____
Personal health	_____	_____	_____	_____	_____

30. List everything not included on this questionnaire that may cause you problems in a fitness test or fitness program:

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**Action Codes**

**EI** = Emergency Information- must be readily available

**MC**= Medical Clearance needed-do not allow exercise without physician’s permission.

**SEP**= Special Emergency Procedures needed- do not let participant exercise alone; make sure the person’s exercise partner knows what to do in case of an emergency

**RF**= Risk Factor of CHD (educational materials and workshops needed).

**SLA**= Special or Limited Activities may be needed- you may need to include or exclude specific exercises.

**Other (not marked)** = Personal information that may be helpful for files or research.