

## SAMPLE HEALTH-HISTORY QUESTIONNAIRE

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Sex  M  F

Physician's Name \_\_\_\_\_

Physician's Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Person to contact in case of emergency:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Are you taking any medications, supplements, or drugs? If so, please list medication, dose, and reason.

---

---

---

Does your physician know you are participating in this exercise program?

---

Describe any physical activity you do somewhat regularly.

---

---

Do you now have, or have you had in the past:	Yes	No
1. History of heart problems, chest pain, or stroke	<input type="checkbox"/>	<input type="checkbox"/>
2. Elevated blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
3. Any chronic illness or condition	<input type="checkbox"/>	<input type="checkbox"/>
4. Difficulty with physical exercise	<input type="checkbox"/>	<input type="checkbox"/>
5. Advice from physician not to exercise	<input type="checkbox"/>	<input type="checkbox"/>
6. Recent surgery (last 12 months)	<input type="checkbox"/>	<input type="checkbox"/>
7. Pregnancy (now or within last 3 months)	<input type="checkbox"/>	<input type="checkbox"/>
8. History of breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/>
9. Muscle, joint, or back disorder, or any previous injury still affecting you	<input type="checkbox"/>	<input type="checkbox"/>
10. Diabetes or metabolic syndrome	<input type="checkbox"/>	<input type="checkbox"/>
11. Thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>
12. Cigarette smoking habit	<input type="checkbox"/>	<input type="checkbox"/>
13. Obesity [body mass index (BMI) $\geq 30$ kg/m <sup>2</sup> ]	<input type="checkbox"/>	<input type="checkbox"/>
14. Elevated blood cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
15. History of heart problems in immediate family	<input type="checkbox"/>	<input type="checkbox"/>
16. Hernia, or any condition that may be aggravated by lifting weights or other physical activity	<input type="checkbox"/>	<input type="checkbox"/>

## EXERCISE HISTORY AND ATTITUDE QUESTIONNAIRE

Name \_\_\_\_\_ Date \_\_\_\_\_

General Instructions: Please fill out this form as completely as possible. If you have any questions, DO NOT GUESS.

1. Please rate your exercise level on a scale of 1 to 5 (5 indicating very strenuous) for each age range through your present age:

15-20 \_\_\_\_\_ 21-30 \_\_\_\_\_ 31-40 \_\_\_\_\_ 41-50 \_\_\_\_\_ 51+ \_\_\_\_\_

2. Were you a high school and/or college athlete?

Yes  No If yes, please specify \_\_\_\_\_

3. Do you have any negative feelings toward, or have you had any bad experience with, physical-activity programs?

Yes  No If yes, please explain \_\_\_\_\_

4. Do you have any negative feelings toward, or have you had any bad experience with, fitness testing and evaluation?

Yes  No If yes, please explain \_\_\_\_\_

5. Rate yourself on a scale of 1 to 5 (1 indicating the lowest value and 5 the highest).

Circle the number that best applies.

Characterize your present athletic ability.

1      2      3      4      5

When you exercise, how important is competition?

1      2      3      4      5

Characterize your present cardiovascular capacity.

1      2      3      4      5

Characterize your present muscular capacity.

1      2      3      4      5

Characterize your present flexibility capacity.

1      2      3      4      5

6. Do you start exercise programs but then find yourself unable to stick with them?

Yes  No

7. How much time are you willing to devote to an exercise program?

\_\_\_\_\_ minutes/day      \_\_\_\_\_ days/week

8. Are you currently involved in regular endurance (cardiovascular) exercise?

Yes  No If yes, specify the type of exercise(s) \_\_\_\_\_

\_\_\_\_\_ minutes/day      \_\_\_\_\_ days/week

Rate your perception of the exertion of your exercise program

(circle the number):

(1) Light      (2) Fairly light      (3) Somewhat hard      (4) Hard

9. How long have you been exercising regularly?

\_\_\_\_\_ months      \_\_\_\_\_ years

10. What other exercise, sport, or recreational activities have you participated in?

In the past 6 months? \_\_\_\_\_

In the past 5 years? \_\_\_\_\_

11. Can you exercise during your work day?

Yes     No

12. Would an exercise program interfere with your job?

Yes     No

13. Would an exercise program benefit your job?

Yes     No

14. What types of exercise interest you?

Walking                       Jogging                       Strength training

Cycling                       Traditional aerobics       Racquet sports

Stationary biking       Elliptical striding       Yoga/Pilates

Stair climbing       Swimming                       Other activities

15. Rank your goals in undertaking exercise:

What do you want exercise to do for you? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Use the following scale to rate each goal separately:

Not at all important					Somewhat important					Extremely important
1	2	3	4	5	6	7	8	9	10	

a. Improve cardiovascular fitness \_\_\_\_\_

b. Lose weight/body fat \_\_\_\_\_

c. Reshape or tone my body \_\_\_\_\_

d. Improve performance for a specific sport \_\_\_\_\_

e. Improve moods and ability to cope with stress \_\_\_\_\_

f. Improve flexibility \_\_\_\_\_

g. Increase strength \_\_\_\_\_

h. Increase energy level \_\_\_\_\_

i. Feel better \_\_\_\_\_

j. Enjoyment \_\_\_\_\_

k. Social interaction \_\_\_\_\_

l. Other \_\_\_\_\_

16. By how much would you like to change your current weight?

(+) \_\_\_\_\_ lb      (-) \_\_\_\_\_ lb