

**HEALTH AND LIFESTYLE HISTORY  
QUESTIONNAIRE**

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

Address: \_\_\_\_\_ Phone: (Home) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Phone: (Cell) \_\_\_\_\_

Zip Code \_\_\_\_\_ Phone: ( Work) \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

1. Has a doctor ever told you that you have, or have you experienced any of the following?

- |   |  |                                     |
|---|--|-------------------------------------|
| <input type="checkbox"/> Heart disease        | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Emphysema  |
| <input type="checkbox"/> Skipped heartbeats   | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma     |
| <input type="checkbox"/> Irregular heartbeats | <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Angina               | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Arthritis  |
| <input type="checkbox"/> Heart valve problems | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Bursitis   |
| <input type="checkbox"/> Heart attack         | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Diabetes   |
| <input type="checkbox"/> Heart murmurs        |  |                                     |

Please explain/other: \_\_\_\_\_

\_\_\_\_\_

2. Are you experiencing any of the following?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Back pain              | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Light-headedness   |
| <input type="checkbox"/> Joint or muscular pain | <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Depression         |
| <input type="checkbox"/> Chest pain             | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Insomnia           |
| <input type="checkbox"/> Ankle swelling         | <input type="checkbox"/> Frequent urination  | <input type="checkbox"/> Migraine headaches |

Please explain/other: \_\_\_\_\_

\_\_\_\_\_

3. Please list any medications or dietary supplements you are currently taking (name and reason).

_____	_____
_____	_____
_____	_____
_____	_____

4. Has anyone in your immediate family (father, mother, brother, sister, or children) had any of the following?

- |   |   |                                      |
|---|---|--------------------------------------|
| <input type="checkbox"/> Heart attack             | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Diabetes    |
| <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Stroke           | <input type="checkbox"/> Early death |
| <input type="checkbox"/> Heart operations         |   |                                      |

Please explain/other: \_\_\_\_\_

\_\_\_\_\_

5. Have you ever had any medical conditions for which a doctor has recommended restrictions on physical activity (including surgery)?

No  Yes

Please explain/other: \_\_\_\_\_

\_\_\_\_\_

6. If female, are you pregnant?

No  Yes

7. Do you smoke?

No  Yes If yes, how long?: \_\_\_\_\_ How much?: \_\_\_\_\_

8. Do you drink alcoholic beverages at all?

No  Yes  
 0-4 drinks per week  
 5-14 drinks per week  
 14+ drinks per week

9. Do you drink coffee or colas with caffeine?

No  Yes If yes, amount per day: \_\_\_\_\_

10. Do you usually eat breakfast?

No  Yes

11. Have you had your cholesterol measured within the past year?

No  Yes

If yes, results: \_\_\_\_\_

12. How would you classify your occupation?

Active  Sedentary Occupation: \_\_\_\_\_

13. Check the description that best represents the amount of stress you experience on a daily basis.

No stress  Occasional mild stress  Frequent moderate stress  
 Frequent high stress  Constant high stress

14. Are you presently exercising a minimum of 2 times per week for at least 30 minutes at a time?

No  Yes

If yes, please specify:

Running/jogging  Racket sports  Weight training  
 Walking  Water sports  Aerobic dance  
 Biking  Swimming

Please explain/other: \_\_\_\_\_

\_\_\_\_\_

15. How would you rate your level of fitness at this time? Example : Excellent, Good, Fair, Poor

\_\_\_\_\_