Fitness Questionnaire

Date: _________________________

Personal Information:

Daytime Phone: ___________________________

Evening Phone: ___________________________

Email: ____________________________

Date of Birth: ______________________

Emergency Contact Name & Phone: ____________________________________

Gender: Male ☐ Female ☐

Physician/Provider Information:

Please provide physician/provider information below. It may be necessary to get a physician's clearance prior to starting your workout program. You may call to set up an appointment any time. Please call 210-568-5200 or 568-3296.

Name: ____

Clinic: ____

Phone: ____

Fax: ____

Health History: (Check all that apply)*

- ☐ Congenital heart disease
- ☐ Congestive heart failure
- ☐ Heart disease aggravated by activity
- ☐ Heart attack(s)
- ☐ Heart murmur
- ☐ Bone or joint condition
- ☐ Bypass or cardiac surgery
- ☐ History of stroke
- ☐ History of cancer or lymphedema
- ☐ Palpitations or tachycardia
- ☐ Neurological/MS/Parkinson's
- ☐ Hyper or hypothyroidism
- ☐ Infectious mononucleosis
- ☐ Dizziness/vertigo/fainting
- ☐ Rheumatic fever
- ☐ Pacemaker or IACD
- ☐ None of the above

Other (Please list below)

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*If you checked any of the above statements in this section, consult your healthcare provider before engaging in exercise.

Current/Relevant Health Data: (Check all that apply)*

- ☐ Female over 55
- ☐ Premature menopause without hormones
- ☐ Currently taking blood pressure medication
- ☐ Currently taking medication for congestive heart disease

- ☐ Hysterectomy prior to menopause
- ☐ Currently pregnant or less than six weeks post-partum
- ☐ Male over 45
- ☐ Exercise less than three times a week, less than 30 minutes
- ☐ Do not exercise
- ☐ Currently 20 pounds over ideal weight
- ☐ Shortness of breath
- ☐ Low blood pressure
- ☐ Don't know resting blood pressure
- ☐ Diagnosed high blood pressure (above 140/90) ?
- ☐ Known abnormal blood sugar
- ☐ Shortness of breath while performing normal activities
- ☐ Experiencing frequent light-headedness or fainting
- ☐ Physician currently restricting activity level
- ☐ Irregular heartbeat
- ☐ Current smoker
- ☐ Former smoker-quit less than 10 years ago
- ☐ Diagnosed high cholesterol (Above 240 mg/dL)
- ☐ Leg length difference
- ☐ Cold hands/feet
- ☐ Numbness or tingling in extremities
- ☐ Currently using incontinence products
- ☐ None of the above

☐ Diagnosed with diabetes Diabetes type: ___________________________

Total cholesterol: ____

Which of the following apply to your parents, brothers or sisters?

- ☐ Heart attack or cardiac-related surgery prior to 50 years of age
- ☐ Stroke(s) prior to 50 years of age

*If you checked any of the above statements in this section, consult your healthcare provider before engaging in exercise.

History of Health Problems (Check all that apply)

☐ Bursitis	☐ Abnormal chest x-ray	☐ Broken bones
☐ Migraine/headaches	☐ Foot problems	☐ Irregular heartbeat
☐ Poor circulation	☐ Epilepsy or seizures	☐ Ulcer
☐ Swollen or stiff joints	☐ Knee problems	☐ Increased anxiety
☐ Asthma	☐ Bronchitis	☐ Stomach or intestinal problems
☐ Arthritis	☐ Back problems	
☐ Anemia	☐ Emphysema	☐ Depression
☐ Hernia	☐ Unusual fatigue	☐ COPD
☐ None of the above		

If any of these conditions are current, please comment:

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Exercise History:

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

☐ Yes ☐ No

If yes, please specify:

☐ Running	☐ Brick walking
☐ Biking	☐ Racquet sports
☐ Golf	☐ Weight training
☐ Cross country ski	

☐ Swimming

☐ Aerobic dance

Other (Please specify):

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Total minutes engaged in cardiovascular activity per week:

☐ 0-20 minutes ☐ 21-40 minutes ☐ 41-60 minutes

☐ 61-80 minutes ☐ 81-100 minutes ☐ 100+ minutes

What are your fitness goals? Please indicate all that apply:

☐ Lose weight ☐ Improve functional fitness

☐ Improve cardiovascular fitness ☐ Reduce stress

☐ Improve flexibility ☐ Lower cholesterol

☐ Stop cigarette smoking ☐ Improve nutrition

☐ Improve muscular condition ☐ Feel better overall

☐ Reduce low back pain

Other (Please specify)

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

☐ No stress ☐ Frequent high stress

☐ Occasional mild stress ☐ Constant stress

☐ Frequent moderate stress

Do you drink caffeinated beverages?

☐ Yes ☐ No

Do you drink alcoholic beverages at all?

☐ Yes ☐ No

If yes, please specify how many alcoholic beverages you consume in an average week:

☐ 0-2 drinks ☐ 3-14 drinks ☐ More than 14 drinks

Note: One drink equals one oz. of hard liquor, 6 oz. of wine or 12 oz. of beer

Medications: (Please list any medications you are currently taking and the reason. Include vitamins, supplements, over the counter, prescriptions)

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Allergies: (Please list)

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Current height: ____________________ Current weight: ____________________

The information I have provided in this Air Force Village Health History Questionnaire is accurate and complete to the best of my knowledge.

Signature: ________________________________ Date: ______________________