

HEALTH HISTORY

(Long Form)

Name:	Age:
Address:	Sex:
Telephone Nos. (daytime): _____ (nighttime): _____	
Current Weight: _____	Desired Weight: _____
Personnel Physician:	
Physician's Address:	

Directions: Please answer the following questions to the best of your knowledge about yourself. Check below any medical condition, treatment or problems that concern you.

I. HEART and CIRCULATORY

- A. _____ Heart Attack, Heart disease or any other heart related problems
- B. _____ Heart Valve Problems
- C. _____ Heart Murmur
- D. _____ Enlarged Heart
- E. _____ Irregular Heart Beat
- F. _____ Atherosclerosis
- G. _____ Stroke
- H. _____ High Blood Pressure (controlled)
- I. _____ High Blood Pressure (uncontrolled)
- J. _____ Rheumatic Fever
- K. _____ Cardiac Surgery
- L. _____ Coronary Bypass
- M. _____ High Triglyceride Level
- N. _____ High Cholesterol Level
- O. _____ Varicose Veins
- P. _____ Anemia
- Q. _____ Hemophilia
- R. _____ Diabetes (controlled)
- S. _____ Diabetes (uncontrolled)
- T. _____ Phlebitis, Emboli (blood clots)
- U. _____ Other, Specify _____

II. RESPIRATORY

- A. _____ Emphysema
- B. _____ Bronchitis
- C. _____ Pneumonia
- D. _____ Asthma: _____ (childhood) _____ (currently)
- E. _____ Lung Disease
- F. _____ Other, Specify _____

III. OTHER DISEASE or ALIMENTS

- A. Back Injuries/Back Pain
- B. Epilepsy/Seizures (past or present)
- C. Allergies
- D. Liver Disease (Hepatitis, Jaundice)
- E. Kidney Disease
- F. Arthritis
- G. Orthopedic Leg, Arm or Joint Problems
- H. Neurologic Diseases
- I. Migraine Headaches/Other Frequent Headaches

Please explain any conditions you checked YES in I-III above:

IV. HAVE YOU RECENTLY HAD:

- A. Chest Pain
- B. Shortness of Breath Upon Exertion
- C. Heart Palpitations
- D. Cough on Exertion
- E. Cough Up Blood
- F. Swollen, Stiff or Painful Joints
- G. Dizziness
- H. Lightheadedness
- I. Fainting
- J. Back Problems
- K. Gastrointestinal Disturbances (nausea, vomiting, diarrhea, abdominal pains)

Please explain any conditions you checked in IV above:

V. FAMILY MEDICAL HISTORY (Immediate Relatives)

- A. Heart Attack, Heart Disease or other heart related problems
- B. Stroke
- C. Atherosclerosis
- D. High Blood Pressure
- E. Diabetes
- F. Lung Disease
- G. Respiratory Problems
- H. Heart Surgery or
- I. Heart Related Surgery
- J. Other, Specify: _____

VI. TOBACCO

A. Do you currently smoke or use tobacco products? _____ Yes _____ No

B. What type? _____ Cigarette
_____ Pipe
_____ Cigar
_____ Chewing tobacco

C. How long? _____

D. Amount smoked per day? _____

E. If you do not currently smoke, have you ever? _____ Yes _____ No

F. If YES, how long ago did you quit? _____

VII. EXERCISE

A. Do you exercise? _____ Yes _____ No

B. What kind of exercise do you presently engage in? _____

C. Is your level of effort: _____ minimal _____ moderate _____ high

D. How often do you exercise? _____ days per week

E. How long do you exercise? _____ minutes per day

Please list any prescription medications, vitamin/nutritional supplements, over-the-counter medications you are currently Taking or have taken in the last 7 days (don't forget to include birth control pills, headache/migraine medications, etc.):

Please describe your present medical condition and anything we should be aware of concerning your health:

Date of last physical examination? _____ Results: _____

Date of last EKG _____ Results: _____

I certify that my responses to the foregoing questionnaire are true, accurate and complete:

Signature: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____
(required for participants under 18 years of age)