

# Health History Questionnaire

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

Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  M  F

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

## HEALTH HISTORY

### 1. Do you have or have you had any of the following?

- |   |  |   |  |
|---|--|---|--|
| Coronary Artery Disease (CAD)           | <input type="checkbox"/> Yes <input type="checkbox"/> No | COPD                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain (angina)                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | (Chronic Obstructive Pulmonary Disease) |  |
| Arrhythmia (irregular/rapid heart beat) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting / Dizziness                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congestive Heart Failure                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ankle Swelling                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Severe Shortness of Breath              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mitral Valve Prolapse                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's/Muscular Disease            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid or Osteoarthritis            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Peripheral Vascular Disease             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Attack                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you pregnant?                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |

### 2. Have you ever had any cardiac related medical/surgical procedures?

If yes, explain: \_\_\_\_\_

## CORONARY ARTERY DISEASE RISK FACTORS

- Do you have a close relative who had a heart attack, coronary revascularization, or sudden death before 55 years of age (father, brother or son) or 65 years of age (mother, sister or daughter)? . . . . .  Yes  No
- Are you a current smoker or have you quit within the previous 6 months? . . . . .  Yes  No
- Is your blood pressure greater than 140/90 or are you taking blood pressure medication? . . . . .  Yes  No
- Is your total cholesterol greater than 200 mg/dl, HDL less than 35 mg/dl, LDL greater than 130 mg/dl, or are you on a lowering medication? . . . . .  Yes  No
- Is your fasting glucose greater than 110 mg/dl (blood sugar)? . . . . .  Yes  No
- Are you physically inactive (you get less than 30 minutes of physical activity on at least 3 days per week?). . . . .  Yes  No
- Body Mass Index (BMI) greater than 30 Weight: \_\_\_\_\_ Height: \_\_\_\_\_ . . . . .  Yes  No
- Are you a man older than 45 or a woman older than 55? . . . . .  Yes  No
- Have you ever been told that your HDL (good cholesterol) is greater than 60 (Negative Risk Factor)? . . . . .  Yes  No

1. Please list medications that are prescribed by your doctor: \_\_\_\_\_

2. Are you receiving or have you received physical therapy? . . . . .  Yes  No

Explain: \_\_\_\_\_

3. Do you have any orthopedic, arthritic, bone/joint problems that may be aggravated by exercise? . . . . .  Yes  No

Explain: \_\_\_\_\_

4. Please check if you have a family history of any of the following:

- CAD  Diabetes  High Blood Pressure  High Cholesterol

**I certify that I have answered the above questions to the best of my knowledge and belief. I understand that the information will be used to determine appropriate screening and testing before the development of my exercise and fitness programs.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PHYSICAL REFERRAL REQUIRED:**  Yes  No

# Medical Clearance

Your Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

DOB: \_\_\_\_\_ Gender:  M  F Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I give my physician permission to release to **Lee Center for Rehabilitation and Wellness** any medical information from my files deemed relevant to my participation in an exercise program.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Lee Center for Rehabilitation and Wellness** requires a physician's approval before the above-named patient can participate in our exercise program. Please complete this form at your earliest convenience and return via Patient or FAX to (239) 418-2091. Your Patient has been advised to wait for your clearance to exercise prior to beginning his/her program.

## RECOMMENDATION:

- Patient has my permission to engage in an exercise program without restriction.
- Patient has my permission to engage in an exercise program **with the following precautions, restrictions, conditions, or limitations** (use back of sheet if necessary):

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- I require the following test(s)/treatments(s) before making a determination concerning this patient. After completion of test/treatment, check appropriate box above.

<u>Test/Treatment</u>	<u>Date Completed</u>
_____	___/___/___
_____	___/___/___
_____	___/___/___
_____	___/___/___

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name (Print): \_\_\_\_\_

*Thank you for taking your valuable time to assist us  
in developing a safe and effective exercise program for your Patient.*