



harvard rec center

cometogether

Health History Questionnaire

Last Name _____ First Name _____ Date _____

Primary Phone _____ E-mail _____ Age _____

Birthday _____ Gender: M F Membership Type: Annual Punch Day Pass Scholarship No-Contract Monthly

1. Are you a male age 46 or older **OR** a female age 56 or older? YES NO
2. Do you have a family history of Myocardial Infarction (heart attack) or sudden death before 55 years of age in father or brother(s) **OR** before 65 years of age in mother or sister(s)? YES NO
3. Do you presently smoke cigarettes **OR** quit within the last 6 months? YES NO
4. Do you have high blood pressure (>140/90) confirmed by 2 separate measurements, **OR** are you taking anti-hypertensive medication? YES NO
5. Do you have high cholesterol (>200 mg) **OR** low HDL (<35 mg) **OR** are you taking cholesterol lowering medication? YES NO
6. Are you a diabetic? YES NO
7. Do you lead a sedentary lifestyle? (Defined as the combination of sedentary jobs involving sitting for a large part of the day **AND** no regular exercise or recreational pursuits). YES NO
8. Do you suffer from chest pains? YES NO
9. Do you often feel faint or have spells of severe dizziness? YES NO
10. Do you have respiratory problems, or have you experienced shortness of breath with normal or daily activities? If yes, explain _____ YES NO
11. Has a doctor ever told you that you have a bone or joint problem such as arthritis, back or shoulder pain or have you suffered a recent orthopedic injury? If yes, explain _____ YES NO

12. Are you under the care of a Physical Therapist, Chiropractor or other Medical Professional for a recent injury, accident, or surgery? If yes, explain _____ YES NO
13. Have you had any major surgeries or illness within the past (6) months? If yes, explain _____ YES NO
14. If you are female, are you **OR** is there a chance you may be pregnant? YES NO
15. Is there any other physical reason that would prevent or hinder your participation in a regular exercise program? If yes, explain _____ YES NO
16. Do you perform aerobic/cardiovascular exercise regularly? YES NO
 If yes, how often _____/week
 At what intensity level? (circle) High Moderate Low
17. Do you perform strength training exercises regularly? YES NO
 If yes, how often _____/week?
18. What are your health and fitness goals?
 _____ Weight management _____ Maintain/increase cardiovascular endurance
 _____ Increase flexibility _____ Maintain/increase muscular strength/tone
 _____ Overall health & well-being _____ Train for a specific sport
 Other: _____

19. Physician _____ Phone _____ Fax _____
 Name Specialty

20. Secondary MD/PT _____ Phone _____ Fax _____
 Name Specialty

21. Signature _____ Parent's Signature _____
 (if under 18 years of age)

I give permission for my physician to suggest exercise recommendations to be released to the Harward Recreation Center for the purpose of setting up an exercise program and/or participating in fitness testing.

Staff use:

HHQ Reviewed by _____ Date _____

_____ No medical clearance needed
 _____ Medical clearance(s) needed

<u>Appointment</u>	<u>Date</u>	<u>Trainers' initials</u>	<u>Type of Appointment</u>
#1	_____	_____	_____
#2	_____	_____	_____
#3	_____	_____	_____
#4	_____	_____	_____

Comments: (12/20)