Colorado State University: Adult Fitness

Personal & Family History Review

Name: _____ Birth Date:_____ Age:____
Last First

SS#:_____ (if you do not have a CSU ID# we need a onetime use of your SS# to issue you an ID for billing)

Address: _____ City:_____ State: ____ Zip:_____

Home/Mobile Phone:_____ Work Phone: _____

Email:_____ Occupation:_____

Marital Status:_____ Education Level:_____

Primary Care Physician:_____ Phone:_____

Emergency Contact: _____ Phone:_____

Please answer each question as completely as you can. If you are unsure, please put a questions mark (?).

I. Family History:

Relation: Age, Health Status; If deceased: Cause of death, Age at death

Father:_____
_____

Mother:_____
_____

Brother(s):_____
_____

Sister(s):_____
_____

Indicate which blood relative (parent, brother, sister, aunt, uncle, grandparent) have had the following conditions and at what age they were diagnosed.

Heart Disease (including heart attack or heart surgery):_____
_____
Stroke:_____
High Blood Pressure:_____
High Cholesterol: _____
Diabetes:_____
Cancer:_____

II. Personal History (Please answer all questions by circling the appropriate x.)

1. Has a doctor ever said you had/have:		No	Yes
1.1	Heart disease?	x	x
1.2	A heart murmur?	x	x
1.3	An enlarged heart?	x	x
1.4	High blood pressure?	x	x
1.5	High cholesterol?	x	x
1.6	A heart attack (coronary, angina, infarct)?	x	x
1.7	An abnormal electrocardiogram (ECG, EKG)?	x	x

2. Has a doctor ever said you had/have:		No	Yes
2.1	A lung or pulmonary disorder?	x	x
2.2	Asthma?	x	x
2.3	Bronchitis or pneumonia?	x	x
2.4	Tuberculosis (TB)?	x	x
2.5	Pulmonary emphysema?	x	x

3. Have you had:		No	Yes
3.1	Thrombophlebitis (blood clots)?	x	x
3.2	Hernia	x	x

4. Has a doctor ever said you had/have:		No	Yes
6.1	Diabetes (Type I or II)?	x	x
6.2	Overactive or underactive thyroid?	x	x
6.3	Bone disease or osteoporosis?	x	x

5. Has a doctor ever said you had/have:		No	Yes
5.1	Arthritis (inflamed) or injured joints?	x	x
5.2	Bursitis or tendinitis?	x	x
5.3	Herniated disc(s)?	x	x

Please provide details for any “yes” answers above (questions 1-5):

6.	Are you currently taking any of the following?	No	Yes
6.1	Asthma medication, sprays, or injections.	x	x
6.2	Narcotic pain medication (codeine, morphine, etc.)	x	x
6.3	Cortisone	x	x
6.4	Blood thinners (Coumadin, etc.)	x	x
6.5	Digitalis or other heart medication	x	x
6.6	High blood pressure medication	x	x
6.7	Hormones	x	x
6.8	Insulin or diabetes medication	x	x
6.9	Iron or anemia medication	x	x
6.10	Diet/weight loss pills	x	x
6.11	Thyroid medication	x	x
6.12	Antacids, ulcer or heartburn medication	x	x
6.13	Other medications	x	x

Please provide details for any "yes" answers above (question 6): Medication name, dose, frequency, etc.

_____

_____

_____

_____

_____

7.	Have you ever had:	No	Yes
11.1	Head injuries bad enough to knock you out?	x	x

8.	Do you have shortness of breath:	No	Yes
8.1	With your usual work or activity?	x	x
8.2	That makes you stop after climbing 10-14 steps?	x	x

9.	Do you have repeated pain/pressure in your chest:	No	Yes
9.1	When you are angry or excited?	x	x
9.2	That awakens you from sleep?	x	x
9.3	During activity that goes away when you rest?	x	x

10.	In the past 6 months have you often had:	No	Yes
10.1	Thumping or racing of the heart?	x	x
10.2	Swelling of one or both feet or ankles?	x	x
10.3	Cramps in your legs while sleeping?	x	x

11.	Have you had pain in your legs that forced you to stop walking and went away after a few minutes of rest?	No x	Yes x

	No	Yes
12. Do you have varicose veins that cause discomfort in your legs?	x	x

	No	Yes
13. Do you often have:		
13.1 Pain in your back that was so bad you were not able to do your usual work?	x	x
13.2 Painful or swollen joints?	x	x

Please provide details for any "yes" answers above (question 7-13):

_____

_____

_____

_____

_____

_____

	No	Yes
14. Do/did you ever smoke cigarettes?	x	x
14.1 Age started:_____		
14.2 Age quit:_____		
14.3 Amount smoked (packs per day): _____		
15. Do you ever smoke cigars or a pipe?	x	x
16. Do you currently drink alcohol?	x	x
How many drinks per week?_____		
(1 drink = 12 oz. beer, 5 oz. wine, 1.5 oz liquor)		

17. What is your present: Weight: _____ lbs Height: ____ ft. ____ in.

18. What is the most you have ever weighed? _____ lbs At what age? _____

	No	Yes
19. In the past 6 months have you:		
19.1 Lost more than 10 lbs.?	x	x
19.2 Gain more than 10 lbs.?	x	x

	No	Yes
20. Have you ever had an injury, surgery, or a problem with any of the following joints?		
20.1 Neck	x	x
20.2 Shoulder	x	x
20.3 Elbow	x	x
20.4 Wrist	x	x

20.5	Hip	x	x
20.6	Knee	x	x
20.7	Ankle	x	x
20.8	Other (Identify:_____)	x	x

21. What are your major health concerns?

_____

_____

_____

_____

22. Please fill in any information below from a recent evaluation or checkup (within the past year). Leave blank if you are unsure.

Resting heart rate: _____
Resting blood pressure: _____
Total Cholesterol: _____
HDL cholesterol _____
LDL cholesterol _____
Fasting blood glucose _____
Other lab results: _____
_____
_____
_____

23. Physical activity: Which category fits you best?

_____ Active: An athlete in training or a person who exercises at a level comparable to running for 30-45 minutes at least 5 days a week.

_____ Moderately active: Planned recreation at least 3 days a week or involvement in a heavy occupation such as construction or farming.

_____ Sedentary: Only normal daily activities such as eating, grooming, working in an office, or attending school.

24. What are your goals for exercise?

_____

_____

_____

_____

_____

_____

25. Describe your current exercise routine (aerobic exercise, strength and/or flexibility training). Also list any exercise preferences you may have.

_____

_____

_____

_____

_____

_____

26. Any additional questions, concerns, or comments:

_____

_____

_____

_____

_____

_____

I herby certify that the answers given in this questionnaire are true and complete. To the best of my knowledge I am in good health. I will notify the program director or staff should my health status change.

_____ _____

Signature Date

_____

Printed Name

(For Office Use Only. Please do not write below this line.)

Technician: _____ Date Administered: _____

Initial Resting Evaluation:

Height: _____
Weight: _____
Body Fat %: _____
Waist Circumference: _____
Blood Pressure: _____ / _____
Heart Rate: _____
Estimated VO_2max: _____

Blood Chemistry:

Fasting glucose: _____
Triglycerides: _____
Cholesterol: _____
HDL: _____
LDL: _____