Health History Questionnaire

Please answer the following questions to the best of your ability. For the following questions, unless otherwise indicated, circle the single best choice for each question. As is customary, all of your responses are completely confidential and may only be used in group summaries and/or reports. All information collected is subject to the Privacy Act of 1974. If you have any physical handicaps or limitations that would require special assistance with this questionnaire, please let your trainer know. This form is in accordance with the American College of Sports Medicine guidelines for risk stratification when followed correctly by your trainer. Your trainer should be certified with a national organization in order to use these forms correctly.

Name:_____ Ht.:_____ Wt.:_____

Gender:_____ Age:_____ Birthdate:_____

Address: _____

City:_____ State:_____ ZIP:_____ Phone:_____

Emergency Contact:_____ Phone: _____

Personal Physician:_____ Phone:_____

E-mail:_____

1. Have you ever had a definite or suspected heart attack or stroke? .....Yes No

2. Have you ever had coronary bypass surgery or any other type of heart surgery? .....Yes No

3. Do you have any other cardiovascular or pulmonary (lung) disease
   (***other than*** asthma, allergies, or mitral valve prolapse)? .....Yes No

4. Do you have a history of: diabetes, thyroid, kidney, liver disease. .....Yes No
   (circle all that apply)

5. Have you ever been told by a health professional that you have had
   an abnormal resting or exercise (treadmill) electrocardiogram (EKG)? .....Yes No

6. If you answered YES to any of Questions 1 through 5, please describe:

_____

_____

_____

_____

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7. Do you currently have any of the following:

a. pain or discomfort in the chest or surrounding areas that occurs when you engage in physical activity? ..... Yes No

b. shortness of breath ..... Yes No

c. unexplained dizziness or fainting ..... Yes No

d. difficulty breathing at night except in upright position ..... Yes No

e. swelling of the ankles (recurrent and unrelated to injury) ..... Yes No

f. heart palpitations (irregularity or racing of the heart on more than one occasion) ..... Yes No

g. pain in the legs that causes you to stop walking (claudication) ..... Yes No

h. known heart murmur ..... Yes No

Have you discussed any of the above with your personal physician? ..... Yes No

8. Are you pregnant or is it likely that you could be pregnant at this time? ..... Yes No
   If yes, what is your expected due date?_____

9. Have you had surgery or been diagnosed with any disease in the past 3 months? ..... Yes No
   If yes, please list date_____ and surgery/disease_____

10. Have you had high blood cholesterol or abnormal lipids within the past 12 months or are you taking medication to control your lipids? ..... Yes No

11. Do you currently smoke cigarettes or have quit within the past 6 months? ..... Yes No

12. Have your father or brother(s) had heart disease prior to age 55 OR mother or sister(s) had heart disease prior to age 65? ..... Yes No

13. Within the past 12 months, has a health professional told you that you have high blood pressure (systolic $\geq$ 140 OR diastolic $\geq$ 90)? ..... Yes No

14. Currently, do you have high blood pressure or within the past 12 months, have you taken any medicines to control your blood pressure? ..... Yes No

15. Have you ever been told by a health professional that you have a fasting blood glucose greater than or equal to 110 mg/dl? ..... Yes No

16. Describe your regular physical activity or exercise program:

    type:_____

    frequency: _____ days per week

    duration: _____ minutes

    intensity: *low* *moderate* *high* **(circle one)**

    BMI: _____

17. If you have answered YES to any of questions 7-16, please describe:

_____

_____

_____

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18. Are you currently under any treatment for any blood clots? ..... Yes No

19. Do you have problems with bones, joints, or muscles that may be aggravated with exercise? ..... Yes No

20. Do you have any back/neck problems? ..... Yes No

21 Have you been told by a health professional that you should not exercise? ..... Yes No

22. Are you currently being treated for any other medical condition by a physician? ..... Yes No

23. Are there any other conditions (mitral valve prolapse, epilepsy, history of rheumatic fever, asthma, cancer, anemia, hepatitis, etc.) that may ***hinder*** your ability to exercise? ..... Yes No

24. During the past six months, have you experienced any ***unexplained*** weight loss or gain (greater than ten pounds for no known reason)? ..... Yes No

25. If you have answered YES to any of questions 18-24, please describe:

_____

_____

_____

26. Please list below all prescription and over-the-counter medications you are currently taking:

Medicine:	Reason for taking:	Dosage:	Amount/Frequency:

27. Are there any medicines that your physician has prescribed to you in the past 12 months which you are currently not taking? ..... Yes No
If so, please list:

_____

_____

_____

I have answered the Health History Questionnaire questions accurately and completely. I understand that my medical history is a very important factor in the development of my fitness/wellness program. I understand that certain medical or physical conditions which are known to me, but that I do not disclose to my trainer, may result in serious injury to me. If any of the above conditions change, I will immediately inform my trainer of those changes. I, knowingly and willingly, assume all risks of injury resulting from my failure to disclose accurate, complete, and updated information in accordance with the attached questionnaire. I also understand that in order to properly risk stratify my Health History Questionnaire, my trainer should have a minimum of a national certification as a personal trainer. My trainer also verbally explained this statement to me to my understanding.

Client's Signature:_____ Date: _____

Trainer's Signature:_____ Date: _____

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Check the identified ACSM major coronary risk factors below:

_____ Lipids (TCH ≥ 200 OR HDL < 35)
_____ Family History
_____ Diabetes/glucose ≥ 110 mg/dl
_____ BMI ≥ 30
_____ Metabolic Disease
_____ Signs or Symptoms of Cardiovascular Disease
_____ Cardiovascular Disease

_____ Cigarette Smoking (or quit within the past 6 months)
_____ High Blood Pressure/Blood Pressure Medications
_____ Sedentary
_____ Pregnancy
_____ Respiratory Disease (asthma, emphysema, chronic bronchitis)

Risk Stratification	Factors
_____ Apparently Healthy	One or No Risk Factors (No medical clearance required)
_____ Apparently Healthy Male ≥ 45; Female ≥ 55	One or No Risk Factors (Initial medical clearance required)
_____ High Risk, No Signs or Symptoms	Two or More Risk Factors (medical clearance required)
_____ High Risk, with Signs and Symptoms	One or More Signs/Symptoms With or Without Risks (medical clearance required)
_____ Known Disease	Diagnosed Cardiopulmonary/Metabolic Disease (annual medical clearance required)
_____ Pregnancy	Medical Clearance Required

All clients needing written medical clearance from their personal physician must give it to their trainer prior to beginning their exercise program.

Additional Comments: _____

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Health History Questionnaire follows the American College of Sports Medicine recommendations for risk stratification. This must be performed on all clients in order to determine the need for medical clearance and/or exercise modifications. Any trainer or those making exercise recommendations should be certified in the proper use of the risk stratification process through a national organization.

If a client has a YES response to anything on page 1, he/she has KNOWN DISEASE, and must have medical clearance prior to beginning exercise.

If he/she has a YES response to anything on #7 a-h on page 2, your client is HIGH RISK WITH SIGNS/SYMPTOMS and must have medical clearance prior to exercise. If your client has a YES response to questions # 8 or 9, he/she must have medical clearance.

YES responses to two or more on questions 10-16 on page 2, your client is HIGH RISK WITHOUT SIGNS OR SYMPTOMS and must have medical clearance (unless he/she also has a YES answer in question #7 making them still HIGH RISK WITH SIGNS/SYMPTOMS).

All other questions on page 3 are at your own discretion. Remember, **when in doubt, refer out.** Please also refer to the most recent edition of *ACSM's Guidelines for Exercise Testing and Prescription* (Williams & Wilkins) as well as the most recent edition of the *ACE Personal Trainer Manual* (American Council on Exercise) for more explanations on the risk stratification. It is your responsibility as a trainer to remain updated on all changes or modifications for risk stratification in determining the need for medical clearance and exercise modifications/recommendations.

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Premier Performance, Inc.
1457 Cambridge Common
Decatur, Georgia 30033
404-406-2873
pperform@bellsouth.net

ACE
AMERICAN COUNCIL ON EXERCISE

American Council on Exercise
4851 Paramount Dr.
San Diego CA 92123
800-825-3636
www.ACEfitness.org