

Health History Inventory

(Long Version)

Please answer each of the questions in this inventory to the best of your ability. For each question, please mark the best choice, unless otherwise indicated. In some instances, you will need to write out your response. If you need assistance with answering any of these questions, please request assistance from a fitness professional. All of your responses will be treated in a confidential manner.

GENERAL INFORMATION

Name: _____

Gender: Male Female Birth Date: _____ Height: _____ ft. _____ inches Weight: _____ pounds

Address: _____

City: _____ State: _____ ZIP: _____

Phone (office): _____ Phone (cell): _____

Phone (home): _____ E-mail: _____

Marital Status: _____ Highest Level of Education Attained: _____

Occupation: _____

Primary Care Physician: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone (office): _____

Program Goals (i.e., your training objectives): _____

PART I: PAST MEDICAL HISTORY

- | | | |
|---|------------------------------|-----------------------------|
| 1. Have you ever been told by a doctor that you have or had heart problems, an abnormal EKG, or had a heart attack or stroke? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Have you ever had coronary by-pass surgery, angioplasty, or any other type of heart surgery? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have you ever had difficulty breathing or become short of breath with mild or light exertion? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Do you have a history of diabetes or thyroid, kidney, or liver disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Have you ever experienced irregular heartbeat (arrhythmia) or been diagnosed with a heart condition or disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. If you answered YES to any of the above questions, please provide additional information below: | | |

PART II: CURRENT MEDICAL HISTORY

- | | | |
|---|------------------------------|-----------------------------|
| 7. Do you currently experience or have any of the following: | | |
| a. Pain or discomfort in the chest or surrounding areas that occurs when you engage in exercise or physical activity? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Shortness of breath with activity or at rest? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Unexplained dizziness or fainting? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Difficulty breathing at night, except in an upright position? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Swelling in the ankles or lower extremities (other than due to an injury)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Heart palpitations (rapid or irregular heart beat of the heart)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Pain in the legs that may cause you to stop walking? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Known heart murmur? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

8. Are you pregnant or is it likely that you may become pregnant at this time? _____ Yes No
 If you are pregnant, what is your expected due date? _____
9. Have you had surgery, or been diagnosed with any disease in the past three months? Yes No
 If you answered yes to question 9, please list the date _____
 And nature of the surgery/disease: _____
10. In the past 12 months, have you been told by a healthcare professional that you have an elevated cholesterol level or abnormal lipid profile, or are you on any medications to control your blood lipids? Yes No
11. Do you currently smoke cigarettes, or have you quit within the past six months? Yes No
12. Have your father or brother(s) had heart disease prior to the age of 55 or mother or sister(s) had heart disease prior to age 65? Yes No
13. Within the past 12 months, has a healthcare professional told you that you have high blood pressure? Yes No
 (systolic >140 mmHg, diastolic >90 mmHg)
14. Do you currently have high blood pressure, or are you taking medication(s) to manage high blood pressure? Yes No
15. Within the past 12 months, have you been told by a healthcare professional that you have an elevated fasting blood glucose level? (>100 mg/dl) Yes No
16. Are you currently under the care of a healthcare professional for blood clots or other circulatory problems? Yes No
17. Do you currently experience problems or pain in your bones, joints, or muscles that may be aggravated with exercise? Yes No
18. Do you currently experience any back and/or neck discomfort or problems? Yes No
19. Are you currently under the care of a healthcare professional for any other health/medical problems? Yes No
20. If you have answered YES to any of the questions in part II (questions 7-19), please provide additional information below:

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

Medicine	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

22. Are there any medications that your physician and/or healthcare professional have prescribed for you in the past 12 months that you are currently not taking? Yes No
 If you answered yes, please list the medications? _____

PART III: PHYSICAL ACTIVITY/EXERCISE HISTORY

23. Please list any favorite activities you would like to include in your exercise plan.

24. Please list any activities you dislike or do not want to include in your exercise plan.

25. Please list any fitness activities (e.g., jogging, cycling, strength training) that you participate in regularly (include how often, how hard, and how long).

26. Please list any recreational activities (e.g., golf, tennis) that you participate in regularly (include how often).

27. Where do you plan to exercise (e.g., club, home, outdoors)?

28. If you plan to exercise at home, list all available equipment.

29. Have you been told by a healthcare professional that you should not exercise?

Yes

No

30. If you answered YES to question #29 in part III, please describe below:

PART IV: WEIGHT HISTORY

31. What do you consider to be your ideal body weight? _____

32. What has been your lowest body weight as an adult (list how old you were)? _____

33. What has been your highest body weight as an adult (list how old you were)? _____

34. What is your current weight? _____

35. What was your weight one year ago? _____

PART V: DIET/NUTRITION HISTORY

36. How many meals do you typically eat per day? _____

37. Do you eat a variety of foods from each of the food groups?

Yes

No

38. Do you try to limit the amount of fat you eat to <30% of your total daily caloric intake?

Yes

No

39. Do you use sugar sparingly by adding little or none to the foods you eat and by limiting your intake of desserts, candy, and soft drinks?

Yes

No

40. Do you limit your alcohol consumption to 1-2 drinks or fewer per day?

Yes

No

41. If you answered NO to any of the questions in part V (questions 37-40), please describe below:

I have answered the questions in this Health History Inventory to the best of my ability, and as accurately and completely as possible. I understand that this information is kept strictly confidential and is used only for the purpose of helping the health/fitness professional make the most appropriate recommendations and design a safe and effective physical-activity program to meet my unique needs. Furthermore, I understand that this information cannot be released to any other party without my prior written approval in accordance with the Health Insurance Portability and Accountability Act of 1996. I understand that my failure to disclose health, medical, or related information that might affect my participation in physical activity may limit the ability of the health/fitness professional to provide the safest possible physical-activity program. Finally, I understand that the information collected in this Health History Inventory has been designed using the recommendations provided by the American College of Sports Medicine for risk stratification as described in their publication, *ACSM's Guidelines for Exercise Testing and Prescription*, 7th edition (2006).

Client/member signature: _____ Date: _____

Staff/trainer signature: _____ Date: _____

For Use by a Qualified Fitness Professional—Health History Inventory II

1. Check off the major coronary risk factors as described by the American College of Sports Medicine in their publication, *ACSM's Guidelines for Exercise Testing and Prescription*, 7th edition (2006).

- Dyslipidemia (total cholesterol over 200 mg/dL, LDL over 130 mg/dL, HDL less than 40 mg/dL, or on lipid medication)
- Hypertension (systolic BP >140 mmHg, diastolic BP >90 mmHg as confirmed by two measurements)
- Cigarette smoking (current smoker or stopped within the past 6 months)
- Impaired fasting glucose (fasting level >100 mg/dL)
- Obesity (body mass index >30; waist/hip ratio greater than 0.95 for men and 0.86 for women)
- Sedentary lifestyle (person does not participate in a regular exercise program)
- Family history (history of heart attack or heart surgery before age 55 on the male side of the family and before age 65 on the female side of the family)

2. Risk Stratification

- Low Risk (men < age 45 or women < age 55 who are asymptomatic and have no more than one risk factor)

No physician clearance required for this person to engage in a program of moderate physical activity.

- Moderate Risk (men > age 45 and women > age 55, or those who have two or more risk factors at any age)

Physician/medical clearance required before this person can engage in a program of moderate physical activity.

- High Risk (individuals having one or more signs or symptoms, or having known cardiovascular, pulmonary, or metabolic disease)

Physician/medical clearance required before this person can engage in a program of moderate physical activity.

Additional Comments: _____

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