_____ Date
_____ Approved

Union University
Department of Campus Recreation
Health History Questionnaire

Personal

Name: _____
Last First MI

Home Address: _____

_____

Email Address: _____

Home Phone: _____

Medical Information

Physician: _____
Address:_____
_____
Phone: _____

Emergency Contact: _____
Phone Number: _____
Relationship: _____

Physical Activity Readiness Questionnaire

YES	NO	
___	___	1. Has your doctor ever said that you have a heart condition AND that you should only do physical activity recommended by a doctor?
___	___	2. Do you feel pain in your chest when you do physical activity?
___	___	3. In the past month, have you had chest pain when you were not doing physical activity?
___	___	4. Do you lose your balance because of dizziness or do you ever lose consciousness?
___	___	5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
___	___	6. Is your doctor currently prescribing drugs for your blood pressure or heart condition?
___	___	7. Do you know of any other reason why you should limit physical activity?

List any allergies that you may have:

_____

_____

Medical History

1. Date of Birth: ___/___/___
2. Date of last physical exam: ___/___/___
3. Please circle any of the following for which you have been diagnosed or treated by a health physician:

Diabetes	Anemia	Emphysema	
Rheumatoid Arthritis	Asthma	Epilepsy	
Bleeding Trait	Obesity	Heart Problem	
Stroke	Concussion	Hypoglycemia	
High Blood Pressure	Kidney Problem	Neck Strain	Back Strain

4. List all medication taken within the past 6 months:

_____

_____

5. Any of these health symptoms that occur frequently can indicate a need for medical attention. Circle the number indicating how often you have each of the following:

5- very often 4-fairly often 3-sometimes
2-infrequently 1-almost never 0-never

a. cough up blood	b. abdominal pain	c. low back pain
0 1 2 3 4 5	**0 1 2 3 4 5**	**0 1 2 3 4 5**
d. leg pain	e. arm or shoulder pain	f. chest pain
0 1 2 3 4 5	**0 1 2 3 4 5**	**0 1 2 3 4 5**
g. swollen joints	h. feel faint	i. dizziness
0 1 2 3 4 5	**0 1 2 3 4 5**	**0 1 2 3 4 5**
j. breathless with slight exertion		
0 1 2 3 4 5		

7. Do you smoke now? Yes No
8. Do you exercise regularly? Yes No
9. List everything not already included on this questionnaire that might cause you problems in a fitness test or fitness program:

_____

_____

Should there be any change in your health, please notify the department of wellness services.

I agree to report any changes in my health to the department of wellness services.

Signature: Date: