SAN FRANCISCO STATE UNIVERSITY
CAMPUS RECREATION

MASHOUF WELLNESS CENTER
CAMPUS RECREATION DEPARTMENT
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Health History Questionnaire

All client information is kept confidential and will only be used by authorized personnel to ensure you are being provided a safe and effective workout environment.

Date of Birth ____/____/____ Age _____ Height (ft' in") _____ Weight (lb.) _____ Sex _____

YES	NO	
☐	☐	Do you have any personal history of heart disease, chest pains, or stroke?
☐	☐	Any personal history of diabetes or other metabolic disease (thyroid, renal, liver)?
☐	☐	Any personal history of pulmonary disease, asthma, or cystic fibrosis?
☐	☐	Any personal history of low or high cholesterol?
☐	☐	Do you experience any light-headedness or chest pains during physical activity?
☐	☐	Have you had any problems with dizziness or fainting?
☐	☐	Do you have difficulty breathing at any time of day or night?
☐	☐	Have you experienced a rapid throbbing or fluttering of the heart?
☐	☐	Do you suffer from joint edema (swelling)?
☐	☐	Do you experience any joint or bone pain during physical activity?
☐	☐	Do you have a known heart murmur?
☐	☐	Do you suffer from health issues related to blood pressure?
☐	☐	Are you a smoker or have you quit smoking within the last 6 months?
☐	☐	Do you drink alcohol more than three times per week?
☐	☐	Do you have a Body Mass Index (BMI) of 25 (kg/m^2) or over?
☐	☐	Are you currently expecting or plan to become pregnant within the next six months?
☐	☐	Would you characterize your lifestyle as sedentary?
☐	☐	Have you ever been advised to exercise by a physician or medical professional?
☐	☐	Do you have any family history of cardiac, metabolic, or pulmonary disease?

When were you last seen by a physician? _____

Has your physician imposed any physical activity restrictions? *If yes, please describe.*

_____

_____

Check any of the following which currently apply or have previously applied to you:

☐ Heart Problems	☐ Chest Pains	☐ Shortness of Breath at Rest
☐ Fainting or Dizziness	☐ Allergies	☐ Low or High Blood Pressure
☐ Seizures	☐ Diabetes	☐ Lower Back Pain
☐ Anemia	☐ Asthma	☐ Arthritis or Gout
☐ Anxiety or Depression	☐ Hernia	☐ Bodily Pains
☐ Acute Infection	☐ Cancer	☐ Recent Surgery (last 12 mo.)
☐ Recent Bone Injury	☐ Stomach Problems	☐ Pregnant or Recently within the last 3 months

Please explain any conditions you checked above (i.e. treatment, symptoms, and restrictions).

_____

_____

_____

Have you been told you have high cholesterol levels by your doctor?
If yes, please list cholesterol levels and any interventions currently being used to manage your cholesterol.

_____

_____

Are you currently taking any medications, supplements, or drugs (prescribed or un-prescribed)?
If yes, please list and explain.

_____

_____

Are there any other medical conditions or health issues, both past and present, not previously mentioned that may affect your ability to exercise?
If yes, please explain.

_____

_____

I, _____, verify that I have informed SFSU Campus Recreation and my Personal Trainer of any existing medical conditions that might require special consideration or clearance before beginning an exercise program. I further certify that my answers stated on both the Physical Activity Readiness Questionnaire and Health History Questionnaire are true and complete. I also understand that this information is an important component of my initial consultation and that I may be asked to update information periodically. Additionally, it is my responsibility to inform my Personal Trainer of any changes in medical condition.

_____ _____

Client Signature Date