

A.E. FINLEY YMCA HEALTH HISTORY QUESTIONNAIRE

NAME _____ DOB _____

PHONE (H) _____ (C) _____

EMERGENCY CONTACT _____ PHONE _____

PHYSICIAN _____ PHONE _____

CURRENT HEIGHT _____ CURRENT WEIGHT _____

PLEASE CHECK ALL THAT APPLY:

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Other heart surgery | <input type="checkbox"/> You experience chest discomfort with exertion |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> You experience unreasonable breathlessness |
| <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> You experience dizziness, fainting, or blackouts |
| <input type="checkbox"/> Heart valve disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> You experience unexplained heart palpitations/rhythms |
| <input type="checkbox"/> Cardiac catheterization | <input type="checkbox"/> Epilepsy | |
| <input type="checkbox"/> Coronary angioplasty | <input type="checkbox"/> Fibromyalgia | |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Emphysema | |
| <input type="checkbox"/> Implantable cardiac defibrillator | <input type="checkbox"/> Chronic Bronchitis | |
| <input type="checkbox"/> Heart transplantation | <input type="checkbox"/> Osteoporosis | |
| | <input type="checkbox"/> Pregnant | |

Note: If you marked any of the above statements, your physician will need to complete a medical clearance form before you can start your exercise program at the A.E. Finley YMCA.

Cardiovascular risk factors:

- | | |
|---|--|
| <input type="checkbox"/> You smoke | <input type="checkbox"/> You are physically inactive |
| <input type="checkbox"/> You are a man older than 45 years | |
| <input type="checkbox"/> You are a woman older than 55 years or you have had a hysterectomy or you are post menopausal | |
| <input type="checkbox"/> Blood pressure is > 140/90, you take blood pressure medication, or you don't know your blood pressure | |
| <input type="checkbox"/> Cholesterol level is > 240 mg/dl, use cholesterol lowering medication, or cholesterol level is unknown | |
| <input type="checkbox"/> Close blood relative had a heart attack before age 55 (father or brother) or age 65 (mother or sister) | |

Note: If you marked 2 or more of the statements in this section, your physician will need to complete a medical clearance form before you can start your exercise program at the A.E. Finley YMCA.

Musculoskeletal risk factors:

- | | | |
|---|--|---|
| <input type="checkbox"/> Head/Neck Injury | <input type="checkbox"/> Hip/Pelvic Injury | <input type="checkbox"/> Calcium Deposits |
| <input type="checkbox"/> Shoulder/Clavicle Injury | <input type="checkbox"/> Knee/Thigh Injury | <input type="checkbox"/> Nerve Damage |
| <input type="checkbox"/> Upper Back Injury | <input type="checkbox"/> Ankle/Foot injury | <input type="checkbox"/> Tennis Elbow |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Bone Fracture | <input type="checkbox"/> Other (Specify: _____) |
| <input type="checkbox"/> Arm/Elbow Injury | <input type="checkbox"/> Arthritis | _____ |
| <input type="checkbox"/> Wrist/Hand Injury | | _____ |

List any current medications and its purpose: _____

List any other concerns regarding your ability to exercise safely: _____

Describe your current exercise/physical activity: _____

Please specify your fitness goals:

- | | | |
|---|--|---|
| <input type="checkbox"/> Increase strength | <input type="checkbox"/> Exercise regularly | <input type="checkbox"/> Improve muscle mass |
| <input type="checkbox"/> Improve cardiovascular fitness | <input type="checkbox"/> Sports conditioning | <input type="checkbox"/> Injury rehabilitation |
| <input type="checkbox"/> Reduce body fat | <input type="checkbox"/> Improve flexibility | <input type="checkbox"/> Other (Specify: _____) |
| | <input type="checkbox"/> Improve muscle tone | _____ |