***Health History Questionnaire***

Name: _____ DOB _____ Gender: M F
Address: _____
Phone: _____ Home Cell Work Email: _____
Physician's Name: _____ Phone: _____

**I. Coronary Profile** (please circle "yes" or "no" to the following questions)

Y N Do you have a history of high blood pressure (>**140** systolic or > **90** diastolic)?
Y N Are you taking medication for high blood pressure? If yes, what: _____
Y N Have you ever been told that your blood cholesterol was high (200 or higher)?
Cholesterol value (if known) _____
Y N Do you currently smoke? If yes, how much? _____ For how long? _____
Y N Have you been a smoker within the past 5 years? If yes, when did you stop? _____
Y N Are you diabetic? Do you take insulin? Y N
Y N Has your physician ever told you to lose weight? If yes, how much? _____
Y N Do you have a BMI > 30 or a waist circumference > 40 inches (male) or >35 inches (female)
Y N Has anyone in your immediate family had a heart attack, stroke, heart surgery, or chest pain?
Y N Do you participate in at least 30 minutes of moderate physical activity at least three days a week?

**II. Cardiopulmonary / Metabolic Profile**

Y N Has a physician ever told you that you have a heart or lung problem? If yes, please describe: _____
_____
Y N Do you get unusually short of breath with very light exertion?
Y N Do you ever have pressure or discomfort in the chest area during heavy activity?
Y N Do you ever feel "skips" palpitations, or runs of fast heart beats in your chest?
Y N Do you ever have dizzy spells or feelings of faintness?
Y N Do you regularly get lower leg pain during walking?

**III. Health / Fitness History**

Y N Are you currently involved in a regular exercise program? If yes, please list activities, duration, frequency and intensity: _____
Y N Do you use alcohol? If yes, how much per week? _____
Y N Do you drink coffee or caffeinated beverages? If yes, how much per day? _____
Y N Are you now, or have you ever been on a diet? If yes, what type? _____
Y N Do you consider yourself overweight? By how many pounds? _____
Y N Do you usually eat breakfast?

1. How would you describe your nutritional habits? (please circle)

   Good Fair Poor

2. Describe your knowledge of nutrition. (please circle)

   Good Fair Poor

3. How many meals do you usually eat per day? _____
4. How many times per week do you usually eat the following?

   Beef _____ Fish _____ Pork _____ Poultry _____

   Desserts _____ Fried Foods _____ Fast Food _____ Eggs _____

5. Which of the following do you regularly use? (please circle)

   Butter Margarine Sugar Sweeteners Salt Whole Milk

6. How active do you consider yourself to be? (please circle)

   Sedentary  Lightly Active  Moderately Active  Highly Active

7. Describe your knowledge of exercise and fitness. (please circle)

   Good  Fair  Poor

8. How would you characterize your life? (please circle)

   Low in stress  Moderately Stressful  Highly Stressful

**IV. Medical History** (please check any condition that you have or have had in the past)

- ☐ Anemia
- ☐ Amenorrhea
- ☐ Ankle Swelling
- ☐ Arthritis
- ☐ Asthma/Bronchitis
- ☐ Anxiety or depression
- ☐ Back problems
- ☐ Broken bones
- ☐ Cancer (specify below*)
- ☐ Celiac Disease
- ☐ Chronic cough
- ☐ Chronic sinus condition
- ☐ Cold hands or feet (all the time)
- ☐ Disordered Eating
- ☐ Emotional disorders
- ☐ Emphysema
- ☐ Epilepsy or seizures
- ☐ Fatigue or lack of energy
- ☐ Foot problems
- ☐ Gastrointestinal disease
- ☐ Heart murmurs
- ☐ Hernia
- ☐ HIV/AIDS
- ☐ Immune system disease
- ☐ Insomnia
- ☐ Joint problems
- ☐ Kidney disease
- ☐ Knee problems
- ☐ Liver problems
- ☐ Low blood pressure
- ☐ Lung disease/shortness of breath
- ☐ Menopausal symptoms
- ☐ Metabolic disease
- ☐ Migraines
- ☐ Neck problems
- ☐ Neuromuscular disease
- ☐ Osteopenia/Osteoporosis
- ☐ Peripheral Vascular Disease
- ☐ Phlebitis or Emboli
- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Shoulder problems
- ☐ Skin problems
- ☐ Stomach or intestinal problems
- ☐ Stroke
- ☐ Swollen, stiff or painful joints
- ☐ Surgery (list type and year)
- ☐ Thyroid problems
- ☐ Ulcers

If you checked any of the above, please briefly explain: _____

_____

_____

Have you attended Physical Therapy in the past? Y N If yes, for what? _____

Have you attended Occupational Therapy in the past? Y N If yes, for what? _____

*Cancer Diagnosis: _____ Grade: _____ Date Diagnosed: _____

Types of Cancer Treatments (list all with dates): _____

_____

Y N Are you experiencing Range of Motion difficulties? If yes, which areas are affected? _____

_____

Y N Are you currently experiencing lymphedema? If yes, which areas are affected? _____

_____

What is your current lymphedema treatment? _____

**V. Medications** (please list): _____

_____

I hereby verify that, to the best of my knowledge, the information I have provided on this document is accurate, and furthermore agree to inform Transitions Studio Staff of any changes in my health status.

Signature: _____ Date: _____