The Zone

Family Fitness & Rec. Center, Inc.
P O Box 275, 1702 Market Street, Schellsburg, PA 15559
(814) 733-2424

HEALTH HISTORY QUESTIONAIRE

Last Name _____ First Name _____

Address _____ City _____ State _____ Zip _____
Telephone
Numbers: Home (____)_____ Work (____)_____ Cell (____)_____

Age _____ Date of Birth ____/____/____ Height ____ft ____in Weight _____

Allergies _____

IN CASE OF EMERGENCY, CONTACT:

Last Name _____ First Name _____ Relation _____

Address _____ City _____ State _____ Zip _____
Telephone
Numbers: Home (____)_____ Work (____)_____ Cell (____)_____

Personal Physician _____ Hospital Preference _____

(Please Circle Yes or No)

YES NO Do/Did you/your parents/siblings have a history of heart disease? If yes, whom? _____

YES NO Do you smoke? If yes, how long and how much? _____

YES NO Is your cholesterol > 200 mg/dl? _____

YES NO Have you ever suffered a stroke or heart attack or have a pre-existing heart condition? If yes, explain. _____

YES NO Have you ever experience pain in your chest, neck, jaw, or arm during activity, which was relieved by rest?

YES NO Have you ever experience episodes of shortness of breath, dizziness, or fainting with activity?

YES NO Do you have an unexplained rapid heart beat?

YES NO Have you ever been convicted of a felony or misdemeanor?

YES NO Are you currently pregnant or within six months post-partum?

YES NO Is there any past medical history we should be aware of? Such as: arthritis, bursitis, lung or airway dysfunction, recent broken bones, surgeries, or illnesses? If yes, explain. _____