



## Senior Health History Questionnaire

Name \_\_\_\_\_

Date \_\_\_\_\_

Date of Birth \_\_\_\_\_

Gender(circle):      M      F

Street Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

**Please answer all of the following questions to the best of your ability and knowledge.**

How frequently do you exercise? \_\_\_\_\_ times / day week month (circle)

How do you get exercise? \_\_\_\_\_

Do you smoke? Or have quit smoking in the last year?       Yes    No

Do you frequently have pains in your heart, chest area?       Yes    No

Do you frequently have shortness of breath?       Yes    No

Do you have palpitations, rapid, or irregular heart beat?       Yes    No

Do you have intermittent pain in your legs?       Yes    No

Do you have ankle swelling?       Yes    No

Do you often feel faint or have spells of severe dizziness?       Yes    No

Do you have arthritis? If so where? \_\_\_\_\_       Yes    No

Do you have uncorrected vision problems?  Yes    No      Uncorrected hearing problems?  Yes    No

**Medical History: Have you had the following...**

Heart attack or heart failure? If so, when? \_\_\_\_\_       Yes    No

Heart Surgery? If so, when? \_\_\_\_\_       Yes    No

A pacemaker or other heart device?       Yes    No

Heart murmur?       Yes    No

Coronary Artery Disease?       Yes    No

A heart valve replacement? If so, when? \_\_\_\_\_       Yes    No

A lung disease? What? \_\_\_\_\_       Yes    No

A stroke? If so, when? \_\_\_\_\_       Yes    No

Musculoskeletal or nerve problems? What? \_\_\_\_\_       Yes    No

High Cholesterol? Greater than 200mg/dL? Do you take medications to control it?       Yes    No

Diabetes? If so, do you take medications to control it?       Yes    No

Osteoporosis? Do you take medications for it?       Yes    No

Do you have a good physical reason not mentioned here why you should not follow an activity program?

Yes    No

I understand that exercise programs can create physical stress and possible harmful effects, even death. I agree it is my responsibility to consult with a physician prior to my initiating an exercise program and is my responsibility to communicate concerns to the staff of the RehabGYM. I also understand that exercise equipment can cause injury and take full responsibility for my actions or accidental injury and will use the facilities with care and caution.

Signature \_\_\_\_\_

Date \_\_\_\_\_