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