Normandale Lake Office Park Wellness Center

Health History Questionnaire

Please Print Clearly

PERSONAL INFORMATION					
NAME	LAST		FIRST		
EMAIL		DATE OF BIRTH	____/____/____	EMPLOYER	

MEDICAL HISTORY		
YES	NO	
☐	☐	Have you ever had a heart attack?
☐	☐	Have you ever had coronary bypass surgery or angioplasty?
☐	☐	Have you ever had a stroke?
☐	☐	Have you ever been diagnosed with high blood pressure (systolic > 140mmHg or diastolic > 90mmHg)?
☐	☐	Have you ever been diagnosed with high cholesterol (total cholesterol > 200mg/dl or HDL< 35 mg/dl)?
☐	☐	Have you ever been diagnosed with diabetes (Type 1 or Type 2)?
Have you ever experienced any of the following?		
☐	☐	Known heart murmur
☐	☐	Pain or discomfort in chest and surrounding areas
☐	☐	Heart flutters or fast heart rate at rest
☐	☐	Pain in limbs that is alleviated by rest but returns with activity
☐	☐	Unusual fatigue or shortness of breath with regular activity
☐	☐	Unusual breathing patterns
☐	☐	Dizziness or fainting
☐	☐	Ankle swelling
Do you have any of the following conditions?		

☐	Asthma	☐	Emphysema	☐	Bronchitis	☐	Hernia
☐	Anemia	☐	Hypoglycemia	☐	Thyroid problem	☐	Cancer
☐	Epilepsy	☐	Phlebitis	☐	Cirrhosis	☐	Arthritis

☐	☐	Do you have chronic back pain or other bone/joint difficulty? Please Specify _____
☐	☐	Are you pregnant?

HEALTH RELATED BEHAVIORS		
YES	NO	
☐	☐	Do you smoke or use tobacco products? If yes, how often? _____
☐	☐	Sedentary lifestyle – combination of a sedentary job with no regular physical activity
☐	☐	Are there any other medical conditions that may affect your use of the fitness center?
		Please explain: _____
Please use the space below to list any medications you are current taking and why you are taking each.		

If you have questions about your health, it is recommended that you consult your physician. Your health is our primary concern. As such, some medical conditions may require us to ask for your physician's approval prior to you participating in any fitness center programs.

I herby verify that the to best of my knowledge, the information I have provided on this form is accurate, and furthermore agree to inform the fitness center staff of any changes in my health status.

SIGNATURE		DATE	_____/_____/_____

HealthSource Solutions is HIPAA compliant. Your information is confidential and secure. All forms are stored in locked file cabinets.