Health and Physical Activity and Health History Inventory

ID ___________________________ Date of Birth ____________________________

Month Day Year

Cardiovascular Disease Symptoms

Indicate the symptoms that you have experienced by circling Yes or No.

1. Pain or discomfort in the chest, neck, jaw, arms or other areas that may be related to poor circulation
   Yes No

2. Heartbeats or palpitations that feel more frequent or forceful than usual or feeling that your heart is beating very rapidly
   Yes No

3. Unusual dizziness or fainting
   Yes No

4. Shortness of breath while lying flat or a sudden difficulty in breathing which wakes you up while you are sleeping
   Yes No

5. Ankle swelling unrelated to injury
   Yes No

6. Shortness of breath at rest or with mild exertion (like walking two blocks)
   Yes No

7. Feeling lame or pain in your legs brought on by walking
   Yes No

8. A known heart murmur
   Yes No

9. Unusual fatigue with usual activities
   Yes No
Recent Health Disturbances

10. Have you had any recent illness?  
   Yes  No

11. If you answered Yes for question 10 please explain.

12. Have you recently been hospitalized?  
   Yes  No

13. If you answered Yes for question 12 please explain.

14. Have you recently had any surgical procedures?  
   Yes  No

15. If you answered Yes for question 14 please explain.

16. Have you recently received antibiotics or a vaccination?  
   Yes  No

17. If you answered Yes to question 16 please explain.

18. Have you recently taken any anti-inflammatory drugs (besides aspirin)?  
   Yes  No

19. If you answered Yes to question 18 please explain.
Appendix III (continued)

Other Habits

20. How many cups of regular coffee do you have daily? _____

21. How many caffeinated soft drinks do you have daily? _____

22. How many cups of tea do you have daily? _____

23. How many cigarettes do you smoke daily? _____

24. How many cigars or pipes do you smoke daily? _____

25. If you are an ex-smoker, how many years since you quit? _____

26. How often would you rate your stress level as high?
   Occasionally  Frequently  Constantly

27. Do you wear dentures? Yes  No

28. Do you wear glasses? Yes  No

29. Do you wear contact lenses? Yes  No

30. Do you take vitamins? Yes  No

31. If you answered Yes to question 30, what type?

32. In your previous job, did you handle or breathe chemicals regularly? Yes  No

33. If you answered Yes for question 32, please explain.
Family History

34. Has any male in your immediate family had a heart attack or sudden death before the age of 55?  Yes  No

35. Has any female in your immediate family had a heart attack or sudden death before the age of 65?  Yes  No

36. Do you have family history of heart disease?  Yes  No

37. Do you have family history of lung disease?  Yes  No

38. Do you have family history of diabetes?  Yes  No

39. Do you have family history of strokes?  Yes  No

40. Please list any thing else you feel we should know about you and your current/past health:

In efforts to maximize safety, we would like to have some emergency information for each of you which the exercise leaders can keep with them. Please fill out the following information:

41. Hospital Preference:_________________________________________________________

Emergency Contacts:

42. Name:_______________________  43. Phone Number:______________
44. Name:_______________________  45. Phone Number:______________

46. Allergies:

47. Chronic Conditions:
Appendix III (continued)

Exercise History

1. In the last 3 months, how many days a week have you spent 30 minutes or more in moderate to strenuous exercise?

   0 1 2 3 4 5 6 7

2. If you have been exercising, what activity have you done most often?

   Walk  Swim  Dance  Bike  Run  Other

3. If you answered Other for question 2, what is the primary other activity that you have done?

4. If you have been exercising, how long has each exercise session been?

   Less than 5 minutes  5-19 minutes  20-30 minutes  More than 30 minutes

5. If you have been exercising, would you say the intensity has been:

   Easy  Moderate  Somewhat Hard  Hard

6. If you have never exercised or are no longer exercising, what is your main reason?

7. Do you frequently lift moderately heavy objects as part of your daily activities?  Yes  No

8. Do you frequently climb stairs as part of your daily activities?  Yes  No

9. Do you regularly engage in informal physical activities?  Yes  No

10. If you circled Yes for question 9, please circle all that apply:

    Gardening  Housework  Walking a pet  Other

11. If you circled Other for question 10 please specify.
Appendix III (continued)

Other Information

1. Age: _______________
2. Height: _____________
3. Weight: _____________
4. Gender: MALE  FEMALE
5. What is your highest level of completed education? Please circle one.

   Did not graduate high school  High School/G.E.D.
   Some college credit  Technical/Associate’s Degree-2 years
   Bachelors/4-year Degree  Graduate Degree (Masters/Ph.D./M.D.)

6. Did you take a college entrance exam, ie: SAT or ACT?

   YES  NO

   If YES, which one? Please circle one

   SAT  ACT

   What was your score? __________________

7. Are you currently in school? Please circle one.

   YES  NO

   If NO, please stop here. If YES, please answer the additional questions.

8. Year in school: FRESH  SOPH  JUNIOR

   SENIOR  GRAD

9. Cumulative G.P.A.:____________________ (if available)