



The Bond Wellness Center

↖ *Monadnock Community Hospital*

HEALTH HISTORY QUESTIONNAIRE

Name: _____
 Telephone No. Home: (____) _____
 Birth Date: ____/____/____ Gender M F
 Best time of day to contact you by phone to schedule an appointment: Time _____ Day: M T W Th F S Su

Date: ____/____/____
 Work: (____) _____
 Vocation: _____

Health History – Please **mark** all true statements

Section I: Cardiovascular Risk Factors

<input type="checkbox"/> You are a man older than 45 years.	<input type="checkbox"/> You have a close relative who had a heart attack or heart surgery before age 55 (father or brother) or before age 65 (mother or sister).
<input type="checkbox"/> You are a woman older than 55 years, have had hysterectomy, or are postmenopausal.	<input type="checkbox"/> You are a diabetic or take medication to control your blood sugar.
<input type="checkbox"/> You smoke, or quit within the previous 6 months. Are you interested in quitting? Y or N	<input type="checkbox"/> You are physically inactive (<30 minutes of physical activity on at least 3 days per week).
<input type="checkbox"/> You have been medically diagnosed with high blood pressure ($\geq 140/90$).	<input type="checkbox"/> You are > 20 pounds overweight.
<input type="checkbox"/> You have been medically diagnosed with abnormal cholesterol (i.e., HDL ≤ 40 mg/dL, LDL ≥ 130 mg/dL and/or total cholesterol >200 mg/dL).	<input type="checkbox"/> You have been medically diagnosed with sleep apnea.

Section II: Cardiovascular History and Symptoms

<u>You have had the following History:</u>	<u>You have had the following Symptoms:</u>
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Chest discomfort or angina with exertion.
<input type="checkbox"/> Heart surgery, including cardiac catheterization or coronary angioplasty. Please describe _____	<input type="checkbox"/> Unreasonable breathlessness at rest or with exertion
_____	<input type="checkbox"/> Dizziness, fainting, blackouts with exertion.
_____	<input type="checkbox"/> Cramps or burning in your lower legs when walking short distances.
<input type="checkbox"/> Pacemaker/implantable cardiac defibrillator	<input type="checkbox"/> Ankle swelling in one or both legs
<input type="checkbox"/> Heart valve disease	<input type="checkbox"/> Blood clot in your legs or lungs in the last 6 months.
<input type="checkbox"/> Abnormal heart rhythm	
<input type="checkbox"/> Heart transplantation	<u>In the past year, have you:</u>
<input type="checkbox"/> Congenital heart disease/defect	Had an exercise stress test? Y N
<input type="checkbox"/> Asthma or other chronic lung disease.	Gained more than 20 lbs? Y N
<input type="checkbox"/> Stroke	Participated in a regular exercise program? Y N

Section III: Other Health Issues

Please check any of the following conditions you now have or have ever had:

<input type="checkbox"/> Currently pregnant	<input type="checkbox"/> Emotional disorders (Type: _____)
<input type="checkbox"/> Cancer (Type: _____)	<input type="checkbox"/> Orthopedic problems. Please describe _____
<input type="checkbox"/> Arthritis (Type: _____)	_____
<input type="checkbox"/> Neurological conditions (Type: _____)	<input type="checkbox"/> Exercise-induced injury. Please describe _____
<input type="checkbox"/> Seizures/Convulsions	_____
<input type="checkbox"/> Memory issues	<input type="checkbox"/> Stomach/Digestive Problems. Please describe _____
<input type="checkbox"/> Chronic pain/condition	_____
<input type="checkbox"/> Balance or gait issues	<input type="checkbox"/> Have impaired vision, hearing or tactile sensation.
<input type="checkbox"/> Have experienced a fall in the past 6 months	
<input type="checkbox"/> Use an assistant device (i.e., cane or walker)	

Please list any surgeries you have had:

Please list all prescribed medications/ nutritional supplements and herbs you are taking.

- | | | |
|----------|----------|-----------|
| 1. _____ | 5. _____ | 9. _____ |
| 2. _____ | 6. _____ | 10. _____ |
| 3. _____ | 7. _____ | 11. _____ |
| 4. _____ | 8. _____ | 12. _____ |

Y N Allergies? Please specify: _____

Physician Information (To expedite your membership, please complete entire section thoroughly)

Primary Physician (First, Last Name): _____ Telephone: () _____

Street Address: _____ City/State: _____ Zip Code: _____

Y N Do you have any medical concerns, limitations, or conditions that should be addressed before participating in an exercise program? Please specify: _____

Y N Any hospitalizations, injuries, or illnesses that have caused you to miss work or limit your activity? Please specify: _____

Physical Activity/Lifestyle

For each of the following questions, please circle Yes or No. Please be sure to read the questions carefully.

Physical activity or exercise includes activities such as walking briskly, jogging, bicycling, swimming, or any other activity in which the exertion is at least as intense as these activities.

For activity to be *regular*, it must add up to a *total* of 30 minutes or more per day and be done at least 5 days per week. For example, you could take one 30-minute walk or take three 10-minute walks for a daily total of 30 minutes.

- | | No | Yes | | No | Yes |
|--|----|-----|--|----|-----|
| 1. I am currently physically active. | 0 | 1 | 3. I currently engage in <i>regular</i> physical activity. | 0 | 1 |
| 2. I intend to become more physically active in the next 6 months. | 0 | 1 | 4. I have been <i>regularly</i> physically active for the past 6 months. | 0 | 1 |

- Do you enjoy exercising as part of a group or in a class setting? Yes No
- Are you interested in using the pools as part of your exercise program? Yes No
- Have you ever been a member of a fitness center? Yes No
- Are you interested in seeing a Nutritionist? Yes No

Please rate your current diet: Excellent Very Good Good Fair Poor

What is your greatest challenge to eating healthy: _____

Do you currently have any dietary restrictions, intolerances, or food allergies? Please Describe _____

Wellness Goals: Please rate your top 3 wellness goals, 1 being your highest priority.

- | | | |
|--|--|-------------------------------------|
| <u> </u> Improve strength | <u> </u> Improve posture | <u> </u> Improve flexibility |
| <u> </u> Injury prevention/rehabilitation | <u> </u> Improve cardiovascular health | <u> </u> Quitting smoking |
| <u> </u> Decrease body fat | <u> </u> Reduce pain | <u> </u> Gain muscle mass |
| <u> </u> Increase energy/endorance | <u> </u> Weight management | <u> </u> Increase muscle tone |
| <u> </u> Reduce stress/Learn ways to relax | <u> </u> Improve sports performance | <u> </u> Learn better eating habits |
| <u> </u> Improve self image | <u> </u> Disease management | <u> </u> Other _____ |

Signature: _____ Staff Representative: _____

Office Use only

Reviewed by: _____ Date: _____

Comments: