BODYWORKS

HEALTH HISTORY QUESTIONNAIRE

Yes	No	Have you ever had?	Yes	No	Has any immediate family (or grandparents) had?	Yes	No	Have you recently had?
☐	☐	High Blood Pressure	☐	☐	Heart Attack(s)	☐	☐	Chest Pain/Discomfort?
☐	☐	Any Heart Trouble	☐	☐	High Blood Pressure	☐	☐	Shortness of Breathe
☐	☐	Disease of the Arteries	☐	☐	High Cholesterol	☐	☐	Heart Palpitations
☐	☐	Varicose Veins	☐	☐	Stroke	☐	☐	Skipped Heart Beats
☐	☐	Lung Disease	☐	☐	Diabetes	☐	☐	Cough on Exertion
☐	☐	Asthma	☐	☐	Congenital Heart Disease	☐	☐	Coughing Up Blood
☐	☐	Kidney Disease	☐	☐	Heart Operation(s)	☐	☐	Dizzy Spells
☐	☐	Hepatitis	☐	☐	Early Death	☐	☐	Frequent Headaches
☐	☐	Diabetes	☐	☐	Mental Illness	☐	☐	Frequent Colds
☐	☐	Heart Murmur	☐	☐	Specify Mental Illness	☐	☐	Back Pain
☐	☐	Arthritis	☐	☐	Depression	☐	☐	Mental Health Treatment
☐	☐	Orthopedic Problems	☐	☐	Other Family Issues	☐	☐	Anxiety
		Past History Score			Family History Score			Present Symptom Score

		Have you been diagnosed with/had:	If yes, please indicate *when* and other requested details.	Score
☐	☐	Diabetes	☐ Type 1 ☐ Type II ☐ HBA1C	
☐	☐	High Blood Pressure	Date and results of last reading	
☐	☐	Cancer		
☐	☐	Lung Disease		
☐	☐	Heart Attack		
☐	☐	Stroke		
☐	☐	Neuromuscular Conditions	(Parkinson's, Multiple Sclerosis, etc.)	

☐ ☐ Are you taking any prescription or non-prescription medication (including birth control). If yes, list:

Medication	Reason For Taking It	How Long Taking It	Score

☐ ☐ Have you ever had your cholesterol measured? If yes, please indicate:
Score: Where: When:

☐ ☐ Have you ever had your glucose (blood sugar) measured? If yes, please indicate:
Score: Where: When:

☐ ☐ Do you drink alcohol? If yes, per week, #____ cans of beer #____ glasses of wine #____ hard liquor drinks

☐ ☐ Do you currently use tobacco? If yes, ☐ cigarettes ☐ cigar ☐ pipe ☐ chew and the #____ each day.

☐ ☐ Have you ever quit smoking? If yes, when _____? How much and # of years did you smoke? _____

☐ ☐ Have you had hospitalizations or surgeries that aren't yet listed? If yes, please describe:

☐ ☐ Do you have any other medical problems/concerns that have not been listed? If yes, please describe:

Signature _____ Date: _____

ACSM Score: _____ Total History Score: _____ Sign: _____ Date: _____
Recommend: _____