



CAMPUS RECREATION

Wellness Center

Health History Questionnaire

OFFICE USE ONLY		
FA	FC	PT
Date	_____	
Time	_____	

THIS FORM MUST BE RETURNED IN PERSON. DUE TO CONFIDENTIALITY, THIS FORM CANNOT BE EMAILED.

Please respond as accurately as possible; the below information will be used to ensure a safe exercise environment. All information will remain confidential unless further professional consultation seems warranted.

Personal Information

Name _____ ID # _____ Date _____

Local Home Address _____ Primary Phone _____

City _____ State _____ Zip _____ Alternate Phone _____

Date of Birth ____/____/____ Age ____ Sex M F Email _____@siue.edu

Status: Student Staff Faculty Alumni Family Other: _____

Year in School: Fresh Soph Junior Senior Grad Major: _____

Emergency Contact Information

Emergency Contact _____ Phone _____

Relationship to you _____

Smoking/Tobacco Usage: Never used Smoke only on occasion Smoke up to ____ (#) (pack)/day
 Use different form of tobacco (cigar) (pipe) (chew) (other) Ex-Smoker (how long _____)

Alcohol Consumption: Never drink drink only on occasion _____ average drinks per week

Caffeine Consumption: Do not consume caffeinated beverages only on occasion _____ average drinks per week

How often would you characterize your stress level as being high? Occasionally Frequently Constantly

Medical Information

How long has it been since your last physical examination?

Less than 1 year 1-2 years 2-3 years 3 or more years

Do you have a personal physician? Yes No*

Personal Physician _____ Physician's Phone _____

Physician's Address _____

Do you have medical alert identification? Yes No *If yes, where is it located?* _____

*If you do not have a current physician, Health Services can provide you with a physical at a cost of \$40.

Have you ever had an abnormal cholesterol reading?

Yes, it was high Yes, it was low
 No, it was normal No, I have not had it checked or do not remember

Have you ever had an abnormal blood sugar reading?

Yes, it was high Yes, it was low
 No, it was normal No, I have not had it checked or do not remember

Please indicate if you have had, or presently have, any of the following:

I do not have any know health conditions

- Abnormality of heart rhythm*
- Allergies:

- Alzheimer's
- Amenorrhea
- Anemia
- Anxiety
- Arthritis
- Asthma*
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism Spectrum Disorder
- Cancer
- Celiac disease
- Cerebral Palsy
- Chronis Obstructive Pulmonary Disease*

- Coronary Artery Disease*
- Crohn's disease
- Dementia
- Depression
- Diabetes (circle): Type I Type II
- Disordered eating or eating disorder
- Down Syndrome
- Epilepsy
- Gastroesophageal reflux disease (GERD)
- Heart failure*
- Hernia
- High blood pressure
- Hypoglycemia
- Hypo/hyperthyroidism
- Insomnia
- Intestinal problems

- Menopausal symptoms
- Narcolepsy
- Osteoporosis
- Paralysis
- Polycystic ovary syndrome (PCOS)
- Post-COVID conditions (including "long COVID")*
- Pregnant
- Psychotic disorder
- Skin problems
- Spinal cord injury
- Stroke
- Ulcer
- *may require medical consent as determined by the trainer

Describe any surgery that you have had within the last two years _____

Have you ever sustained any injury or experienced any type of chronic pain, which has been diagnosed as due to physical activity or sports participation? Yes No If Yes, please explain _____

- Do you or have you recently experienced any of the following signs or symptoms?
- I have not experienced any of these symptoms
 - Ankle swelling
 - Burning/cramping in calves walking short distances
 - Chest discomfort with exertion
 - Dizziness
 - Fainting or blackouts
 - Cramping/numbness/tingling during exercise that is relieved with short periods of rest
 - Known heart murmur
 - Breathing discomfort when lying down
 - Pain/discomfort in the chest, neck, jaw, or arms
 - Rapid, irregular heartbeat
 - Shortness of breath at rest or with mild exertion
 - Resting heart rate over 100 beats per minute
 - Forceful, rapid, or irregular heart rate
 - Unreasonable breathlessness
 - Fatigue/shortness of breath with usual activities

Family History

Have any members of your immediate family been diagnosed with the following:

- Heart disease
- High blood pressure
- Diabetes
- High cholesterol
- Cancer
- Osteoporosis

Condition: _____
Relation: _____
Age of onset: _____

Condition: _____
Relation: _____
Age of onset: _____

Condition: _____
Relation: _____
Age of onset: _____

I am not aware of any family history of the above conditions

EXERCISE STATUS

Level of physical activity? Inactive Low (<150 min*) Medium (150-300 min*) High (>300 min*)

*number of minutes of moderate (raised heart rate) intensity activity per week

How often do you perform cardiovascular exercise for at least 20-30 minutes per session?

No regular program 1 time/week 2 times/week 3-4 times/week 5 + times/week

How often do you weight train?

No regular program 1 time/week 2 times/week 3-4 times/week 5 + times/week

Briefly describe your exercise program _____

HEALTH GOALS

Please indicate your *top three* goals.

<input type="checkbox"/> Improve strength	<input type="checkbox"/> Reduce cholesterol	<input type="checkbox"/> Lose weight/decrease body fat
<input type="checkbox"/> Improve muscle tone & shape	<input type="checkbox"/> Reduce blood pressure	<input type="checkbox"/> Gain weight
<input type="checkbox"/> Improve cardiovascular fitness	<input type="checkbox"/> Increase energy	<input type="checkbox"/> Improve diet/eating habits
<input type="checkbox"/> Improve flexibility	<input type="checkbox"/> Reduce stress	<input type="checkbox"/> Train for a sports-specific event
<input type="checkbox"/> Improve health	<input type="checkbox"/> Prevent injury	<input type="checkbox"/> Rehabilitate injury
<input type="checkbox"/> Other _____		

NUTRITION LIFESTYLE

What is your current weight? _____ lb height? _____ ft. _____ in.

What would you like to weigh? _____ lb

What is the most you ever weighed as an adult? _____ lb What is the least? _____ lb

What weight loss methods have you tried? _____

Which do you eat regularly?

Breakfast Midmorning snack Lunch Afternoon snack Dinner After-dinner snack

How often do you eat out each week? _____ times

What size portions do you normally have? Small Moderate Large Extra-large Uncertain

How long does it usually take you to eat a meal? _____ minutes

Do you eat while doing other activities (e.g., watching TV, reading, working)? _____

Consent for Limited Release of Information

Campus Recreation may need to communicate with other SIUE offices on your behalf. Please initial before each of the following if you consent to the exchange of limited information. If you do not wish for any of your information to be shared, do not initial.

- | | |
|--|---|
| <input type="checkbox"/> SIUE Health Service | <input type="checkbox"/> Disability Support Services |
| <input type="checkbox"/> Counseling Services | <input type="checkbox"/> International Student Services |
| <input type="checkbox"/> Intercollegiate Athletics | |
| <input type="checkbox"/> Mandating Official (please specify) _____ | |
| <input type="checkbox"/> Other (please specify name) _____ | |

You will need to sign a Release of Information Form if you wish to have additional information communicated.

**THIS FORM MUST BE RETURNED IN PERSON.
DUE TO CONFIDENTIALITY, THIS FORM CANNOT BE RETURNED BY EMAILED.**

INFORMATION FOR TRAINERS AND FITNESS COORDINATOR TO COMPLETE

- | | | | |
|------------------------|------------------|----------------------|------|
| Diagnoses*: | Yes | No | |
| Signs or symptoms: | Yes | No | |
| Client activity level: | Currently active | Not currently active | |
| Clearance required: | Yes | No | |
| Client start-level: | Low | Moderate | High |

<hr/> Trainer name printed	<hr/> Trainer signature	<hr/> Date
<hr/> Coordinator name printed	<hr/> Coordinator signature	<hr/> Date