

# Aquatics Program Health History Questionnaire

Please respond to the following items as accurately as possible.  
This information will be used by the evaluator to ensure a safe exercise environment.  
All information will remain confidential unless further professional consultation seems warranted.

Name \_\_\_\_\_ ID # \_\_\_\_\_ Date \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_

Work Address \_\_\_\_\_ Work Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Title \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Sex:  M  F

Status  Student  Staff  Faculty  Alumni  Family

Year in School  Frosh  Soph  Jr  Sr  Grad Major \_\_\_\_\_

**How did you hear about this program?**

Life After Class  Flyer  Website  Class  Friend  Other \_\_\_\_\_

Personal Physician \_\_\_\_\_ Physician's Phone \_\_\_\_\_

Physician's Address \_\_\_\_\_

Individual to be contacted in the event of an emergency \_\_\_\_\_

Relationship to you \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

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

**Smoking Status**

Never Smoked  Smoke up to 1 pk/day  Ex-Smoker (how long \_\_\_\_\_)  
 Smoke up to 2 pk/day  Smoke pipe/cigar only  Smoke only on occasion

**Please list all medications that you are currently taking.**

<i>Name of Drug</i>	<i>Dosage/Frequency</i>	<i>Reason for Taking</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> High blood pressure        | <input type="checkbox"/> Obesity                | <input type="checkbox"/> Hernia                      |
| <input type="checkbox"/> Low blood pressure         | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Dizziness or fainting       |
| <input type="checkbox"/> High blood cholesterol     | <input type="checkbox"/> Glucose intolerance    | <input type="checkbox"/> Unusual shortness of breath |
| <input type="checkbox"/> High blood triglycerides   | <input type="checkbox"/> Hypoglycemia           | <input type="checkbox"/> Chronic Bronchitis          |
| <input type="checkbox"/> Heart attack/heart disease | <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Emphysema                   |
| <input type="checkbox"/> Heart surgery              | <input type="checkbox"/> Phlebitis              | <input type="checkbox"/> Asthma                      |
| <input type="checkbox"/> Heart failure              | <input type="checkbox"/> Thyroid disorder       | <input type="checkbox"/> Exercise-induced asthma     |
| <input type="checkbox"/> Heart murmur               | <input type="checkbox"/> Ankle swelling         | <input type="checkbox"/> Hay fever/other allergies   |
| <input type="checkbox"/> Heart valve disease        | <input type="checkbox"/> Epilepsy or seizures   | <input type="checkbox"/> Emotional disorder          |
| <input type="checkbox"/> Heart palpitations         | <input type="checkbox"/> Back trouble           | <input type="checkbox"/> Eating disorder             |
| <input type="checkbox"/> Chest pain                 | <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Recent hospitalization      |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Osteoporosis           | <input type="checkbox"/> Other: _____                |
| <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Bone or joint problems |  |

Are you, or may you be pregnant?  Yes  No

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 \_\_\_\_\_

Has your weight fluctuated more than a few pounds?  Yes  No

If Yes, please explain \_\_\_\_\_

How long has it been since your last physical examination?

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

What is your current cholesterol level? (Leave blank if you're not sure)

\_\_\_Total \_\_\_LDL \_\_\_HDL \_\_\_Triglycerides

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

- Occasionally  Frequently  Constantly

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

	Mother	Father	Sisters	Brothers	Grandparents
Heart disease	_____	_____	_____	_____	_____
Heart attack (under age 50)	_____	_____	_____	_____	_____
Heart surgery	_____	_____	_____	_____	_____
Stroke (under age 50)	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Pulmonary disease	_____	_____	_____	_____	_____
Sudden death	_____	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____	_____
High cholesterol	_____	_____	_____	_____	_____
Obesity	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____

I hereby state that all of the above information is accurate to the best of my knowledge.

Signature \_\_\_\_\_

Date \_\_\_\_\_