



# Wellness 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 \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_ @siue.edu

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 \_\_\_\_\_

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

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

Address \_\_\_\_\_

### 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

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

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

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

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

Name of Drug	Dosage/Frequency	Reason for Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

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

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 \_\_\_\_\_

## Exercise Status

**Is your occupation?**       Inactive (e.g, desk job)       Light work (e.g., housework, light carpentry)  
 Heavy work (e.g., heavy carpentry, lifting)

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

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

**How often do you weight train?**

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

**Please indicate which weight lifting equipment you use:**    Free Weights    Circuit Machines    Body Weights

**Starting Weight?** \_\_\_\_\_ lbs      **How many sets per muscle group?**    1-3    4-6    7+

**How many repetitions?**    4-6    6-10    8-12    12-15    15-20    >20

**Which muscle groups are emphasized?**

Upper Back     Lower Back     Abdominals     Chest     Biceps     Triceps     Shoulders  
 Hamstrings     Calves     Quads     Other\_\_\_\_\_

**Briefly describe your exercise program** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Fitness Goals

**Please indicate your top three fitness goals.**

____ Improve strength	____ Reduce cholesterol
____ Improve muscle tone & shape	____ Reduce blood pressure
____ Improve cardiovascular fitness	____ Increase energy
____ Improve flexibility	____ Reduce stress
____ Lose weight/decrease body fat	____ Prevent injury
____ Gain weight	____ Rehabilitate injury
____ Improve diet/eating habits	____ Train for a sports-specific event
____ Improve health	____ Other_____

## Exercise Preferences

**How much time are you willing to devote to an exercise program?** \_\_\_\_\_Min/Session    \_\_\_\_\_Days/Week

**On what days of the week would you like to exercise?**      S    M    T    W    Th    F    S

**Mark the activities that you enjoy participating in or would like to try (choose up to 5).**

<input type="checkbox"/> Aerobics	<input type="checkbox"/> Hiking	<input type="checkbox"/> Soccer
<input type="checkbox"/> Active gardening	<input type="checkbox"/> Hockey	<input type="checkbox"/> Stair/bench stepping
<input type="checkbox"/> Backpacking	<input type="checkbox"/> Jogging/running	<input type="checkbox"/> Stretching
<input type="checkbox"/> Baseball/softball	<input type="checkbox"/> Martial arts	<input type="checkbox"/> Swimming
<input type="checkbox"/> Bicycling	<input type="checkbox"/> Mountain climbing	<input type="checkbox"/> Tennis
<input type="checkbox"/> Cross country skiing	<input type="checkbox"/> Racquetball/handball	<input type="checkbox"/> Volleyball
<input type="checkbox"/> Dancing	<input type="checkbox"/> Rollerblading	<input type="checkbox"/> Walking
<input type="checkbox"/> Downhill skiing	<input type="checkbox"/> Rope skipping	<input type="checkbox"/> Weight training
<input type="checkbox"/> Football	<input type="checkbox"/> Rowing	<input type="checkbox"/> Yoga
<input type="checkbox"/> Golfing	<input type="checkbox"/> Skating	<input type="checkbox"/> Other_____

## Nutrition Lifestyle

1. What is your current weight? \_\_\_\_\_lb \_\_\_\_\_kg height? \_\_\_\_\_in. \_\_\_\_\_cm
2. What would you like to weigh? \_\_\_\_\_lb \_\_\_\_\_kg
3. What is the most you ever weighed as an adult? \_\_\_\_\_lb \_\_\_\_\_kg
4. What is the least you ever weighed as an adult? \_\_\_\_\_lb \_\_\_\_\_kg
5. What weight loss methods have you tried? \_\_\_\_\_  
\_\_\_\_\_

6. Which do you eat regularly?

- Breakfast                       Midmorning snack                       Lunch  
 Midafternoon snack                       Dinner                       After-dinner snack

7. How often do you eat out each week? \_\_\_\_\_times

8. What size portions do you normally have?

- Small                       Moderate                       Large                       Extra large                       Uncertain

9. How often do you eat more than one serving?

- Always                       Usually                       Sometimes                       Never

10. How long does it usually take you to eat a meal? \_\_\_\_\_minutes

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

12. When you snack, how many times a week do you eat the following?

- |                             |                                    |                             |
|-----------------------------|------------------------------------|-----------------------------|
| _____ Cookies, cake, pie    | _____ Candy                        | _____ Diet soda             |
| _____ Soft drinks           | _____ Doughnuts                    | _____ Fruit                 |
| _____ Milk or milk beverage | _____ Potato chips, pretzels, etc. | _____ Peanuts or other nuts |
| _____ Ice cream             | _____ Cheese and crackers          | _____ Other _____           |

13. How often do you eat dessert? \_\_\_\_\_times a day \_\_\_\_\_times a week

14. What dessert do you eat most often? \_\_\_\_\_

15. How often do you eat fried foods? \_\_\_\_\_times a week

16. Do you salt your food at the table?     Yes                       No  
 Before tasting it                       After tasting it

## Consent for Limited Release of Information

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

- SIUE Health Service Initial\_\_\_\_
- Counseling Services Initial\_\_\_\_
- Intercollegiate Athletics Initial\_\_\_\_
- Disability Support Services Initial\_\_\_\_
- International Student Services Initial\_\_\_\_
- Mandating Official (please specify) \_\_\_\_\_ Initial\_\_\_\_
- Other (please specify name) \_\_\_\_\_; attendance only. You will need to sign a Release of Information Form if you wish to have additional information communicated. Initial\_\_\_\_