



University of Iowa  
Division of Recreational Services

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### HEALTH HISTORY / PHYSICAL ACTIVITY QUESTIONNAIRE

Name \_\_\_\_\_ Date \_\_\_\_\_

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

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

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

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

Email \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Technician: \_\_\_\_\_

#### General Medical History:

CIRCLE ONE

Date

1. Any medical complaints? \_\_\_\_\_ Yes No \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Have you ever been hospitalized, treated for serious illness, or had surgery? If yes, please explain. \_\_\_\_\_ Yes No \_\_\_\_\_  
\_\_\_\_\_

3. Have you had major surgery or an injury that might hinder or prohibit your participation in an exercise program? If yes, please explain. \_\_\_\_\_ Yes No \_\_\_\_\_  
\_\_\_\_\_

4. Are you currently under a physician's care for any physical health problem? \_\_\_\_\_ Yes No \_\_\_\_\_  
If yes, for what reason \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Are you aware of any problems that would keep you from participating in regular, vigorous physical activity.

Yes No

If yes, explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

6. Are you presently taking any medication (prescription and non-prescription)? Yes No

Medication	Dose	Reason for taking	For how long?

Drug allergies? \_\_\_\_\_

7. Do you have, have you recently experienced, or have you ever had (check those applicable):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> rheumatic fever                        | <input type="checkbox"/> depression                                 | <input type="checkbox"/> stomach problems             |
| <input type="checkbox"/> high cholesterol                       | <input type="checkbox"/> low blood pressure                         | <input type="checkbox"/> hernia                       |
| <input type="checkbox"/> high blood pressure                    | <input type="checkbox"/> valve disease                              | <input type="checkbox"/> limited movement in joints   |
| <input type="checkbox"/> infections                             | <input type="checkbox"/> rapid heart beats or irregular heart beats | <input type="checkbox"/> shoulder problems            |
| <input type="checkbox"/> aneurysm                               | <input type="checkbox"/> disordered eating                          | <input type="checkbox"/> ulcers                       |
| <input type="checkbox"/> asthma                                 | <input type="checkbox"/> migraine                                   | <input type="checkbox"/> anemia                       |
| <input type="checkbox"/> embolism                               | <input type="checkbox"/> back problems                              | <input type="checkbox"/> heart murmur                 |
| <input type="checkbox"/> stroke                                 | <input type="checkbox"/> foot problems                              | <input type="checkbox"/> thrombophlebitis             |
| <input type="checkbox"/> diabetes                               | <input type="checkbox"/> disease of arteries                        | <input type="checkbox"/> angina/chest pain/discomfort |
| <input type="checkbox"/> edema/swelling                         | <input type="checkbox"/> abnormal lack of energy                    | <input type="checkbox"/> respiratory discomfort       |
| <input type="checkbox"/> pneumonia                              | <input type="checkbox"/> arthritis                                  | <input type="checkbox"/> fixed rate pacemaker         |
| <input type="checkbox"/> increased anxiety                      | <input type="checkbox"/> neck problems                              | <input type="checkbox"/> epilepsy/seizure             |
| <input type="checkbox"/> emotional disorder                     | <input type="checkbox"/> bursitis                                   | <input type="checkbox"/> shortness of breath          |
| <input type="checkbox"/> trouble sleeping                       | <input type="checkbox"/> broken bones                               |   |
| <input type="checkbox"/> knee problems                          | <input type="checkbox"/> heart attack                               |   |
| <input type="checkbox"/> lightheadedness, fainting or dizziness | <input type="checkbox"/> heart medications                          |   |
| <input type="checkbox"/> emphysema                              |   |   |
| <input type="checkbox"/> bronchitis                             |   |   |

8. Do any of your immediate family/grandparents have a history of (check those applicable):

- heart disease
- heart surgery
- high cholesterol
- diabetes
- heart attack
- congenital heart disease
- high blood pressure
- stroke
- premature death

If yes, please note relationship and age \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Weight History** (this will remain confidential between you and your trainer)

9. One year ago \_\_\_\_\_ Today \_\_\_\_\_ Maximum Ever \_\_\_\_\_

**Smoking History**

Ever Yes No

10. How long since you quit? How many cigarettes/day?

Now Yes No

**Nutrition History**

11. Do you use alcohol? \_\_\_Yes \_\_\_No If yes, how many per week\_\_\_\_\_

12. Do you drink caffeinated coffee or colas? \_\_\_Yes \_\_\_No If yes, how many per week\_\_\_\_\_

13. Are you now or have you ever been on a diet? \_\_\_Yes \_\_\_No If yes, please explain\_\_\_\_\_

14. Do you consider yourself overweight? \_\_\_Yes \_\_\_No Do you consider yourself underweight? \_\_\_Yes \_\_\_No

15. Number of meals you usually eat per day:\_\_\_\_\_

16. Do you usually eat breakfast? \_\_\_Yes \_\_\_No

17. Number of times per week you usually eat the following:  
\_\_\_\_ Beef \_\_\_\_ Fish \_\_\_\_ Pork \_\_\_\_ Chicken \_\_\_\_ Desserts \_\_\_\_ Fried Foods \_\_\_\_ Fast Food

18. Do you regularly use any of the following: please circle  
Butter Sugar Sweetners Salt Whole Milk

19. How would you describe your nutrition habits? please circle  
good fair poor

20. Please describe your knowledge of nutrition: please circle  
very knowledgeable knowledgeable no knowledge

**Nutritional Profile**

Write down everything you have eaten or drunk in the past 24 hour period. Indicate approximate amount, how food was prepared (fried or baked), food quality (skim milk vs whole milk), and so forth. Be as specific as possible. Indicate where eaten as well.

Breakfast:

Mid-morning:

Lunch:

Mid-afternoon:

Dinner:

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**Signature**

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**Date**