Southeast HEALTH
Fitness

Health History Questionnaire

Personal Information:

Name: _____ Birthday: _____ Circle: M / F

Phone #: _____ Email: _____

Primary physician: _____ How did you hear about us_____

SYMPTOMS

Do you experience any of the following:	**Yes**	**No**
1. Chest discomfort with exertion	☐	☐
2. Unreasonable breathlessness	☐	☐
3. Dizziness, fainting, blackouts	☐	☐
4. Ankle Swelling	☐	☐
5. Unpleasant awareness of a forceful, rapid irregular heart rate	☐	☐
6. Burning or cramping sensations in your lower legs when walking short distances	☐	☐

CURRENT ACTIVITY:

Have you performed planned, structured physical activity for at least 30 minutes at moderate intensity on at least 3 days per week for at least the last 3 months? **Yes / No**

MEDICAL CONDITIONS:

Have you had, or do you currently have, any of the following:	**Yes**	**No**
1. A heart attack	☐	☐
2. Heart surgery, cardiac catheterization, or coronary angioplasty	☐	☐
3. Pacemaker/implantable cardiac defibrillator/rhythm disturbance	☐	☐
4. Heart valve disease	☐	☐
5. Heart Failure	☐	☐
6. Heart Transplantation	☐	☐
7. Congenital heart disease	☐	☐
8. Diabetes	☐	☐
9. Renal disease	☐	☐

My signature certifies that all of the above is true to the best of my knowledge.

Signature: _____