Student Activity and Academic Center
Emory University

Medical Health History

All information given is personal and confidential. The information will enable us to better understand you and your health and fitness habits.

Name_____________________________________ ____________Date ______________

Address____Home Phone___________________

City/State____Zip Code_______________________

E-mail____

Occupation____Bus Phone_____________________

Date of Birth________________Gender________Height________Weight_________Race__________

****

I. Signs and Symptoms

****

Have you ever experienced any of the following:
(please circle yes or no)

yes no 1. Pain, discomfort, tightness or numbness in the chest, neck, jaw or arms.

yes no 2. Shortness of breath at rest or with mild exertion.

yes no 3. Dizziness or fainting.

yes no 4. Difficult, labored or painful breathing during the day or at night.

yes no 5. Ankle swelling.

yes no 6. Rapid pulse or heart rate.

yes no 7. Intermittent cramping.

yes no 8. Known heart murmur.

yes no 9. Unusual shortness of breath or fatigue with usual activities.

If you answered **yes** to any of the above—

How often do you experience the symptom?____

Have you ever discussed the symptom with a doctor?_________________________________

Explain the symptom in more detail:____

____

****

II. Major Risk Factors

****

yes no *dk 1. Do you have a body mass index ≥ 30 or a waist girth >100 cm?

yes no *dk 2. Have you had a fasting glucose of ≥ 110 mg/dl confirmed by measurements on at least 2 separate occasions.

yes no *dk 3. Has your father or brother experienced a heart attack before the age of 55? Or has your mother or sister experienced a heart attack before the age of 65?

yes no 4. Do you currently smoke or quit within the past 6 months?

yes no 5. Has your doctor ever told you that you have high blood pressure?

yes no *dk 6. Do you have high cholesterol?
Total cholesterol:_____________HDL:__________Date tested:_____________

yes no 7. Do you have a sedentary lifestyle? (sitting most of the day in your job with no regular physical activity)

* Don't Know

****

III. Medical Diagnoses

****

Have you ever had any of the following? Circle all that apply:

heart attack	angioplasty	heart surgery	coronary artery disease
angina	hypertension	heart murmur	heart clicks
asthma	emphysema	bronchitis	stroke
anemia	phlebitis	emboli	cancer
osteoporosis	emotional disorders	eating disorders	

Any special problems not listed above:____

If any of the above are circled, please give details and explain:________________________________

____

____

____

____

****

IV. General

****

yes no 1. Are you pregnant?

yes no 2. Do you have arthritis or any bone or joint problem?
If yes, please explain:____

____

yes no 3. Do you currently exercise?
If yes, how long have you been exercising?______________________________

What do you do and how often?__________________________________

yes no 4. Are you taking any medication, vitamins or supplements?
Drug name and dosage / purpose of drug / prescribed or over-the-counter

____

____

____

****

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

Signature:____Date:______________________

****

STAFF USE ONLY

****

Comments:____

Stratification(circle one): Low Risk Moderate Risk High Risk

Resting blood pressure:________________Resting heart rate:________________

yes no Do meds affect BP or HR?

Date:_____________________Initials:______________