



ADELPHI UNIVERSITY

Garden City • New York • 11530

Health/Medical Questionnaire

SCHOOL OF EDUCATION
ADULT FITNESS PROGRAM

tel. (516) 877-4270

fax (516) 877-4258

Name: _____ Date: _____
 Address: _____ Age: _____ Date of Birth: _____
 _____ Sex: _____ Height: _____ Weight: _____
 _____ Home Phone: _____
 _____ Work Phone: _____

In case of emergency contact Mr/Mrs. _____ phone #: _____

Personal Care Physician: _____

Date of last visit: _____ Reason: _____

1. Have you had or do you have:

- | | | |
|--|--|--|
| <input type="checkbox"/> heart attack | <input type="checkbox"/> thrombophlebitis | <input type="checkbox"/> rapid heart beats |
| <input type="checkbox"/> angina | <input type="checkbox"/> asthma | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> abnormal electrocardiogram | <input type="checkbox"/> fixed rate pacemaker | <input type="checkbox"/> low blood pressure |
| <input type="checkbox"/> heart medications | <input type="checkbox"/> embolism | <input type="checkbox"/> high cholesterol |
| <input type="checkbox"/> valve disease | <input type="checkbox"/> respiratory infections | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> aneurysm | <input type="checkbox"/> irregular heart beats | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> cardiac surgery (ex. bypass, stents) | <input type="checkbox"/> peripheral vascular disease | <input type="checkbox"/> anemia |

If yes, please explain _____

2. Has your physician ever advised you against exercise? Yes No
 If yes why and when? _____

3. Do you have any of the following conditions?

- | | | |
|--|--|--|
| <input type="checkbox"/> arthritis | <input type="checkbox"/> ankle/foot injury | <input type="checkbox"/> shoulder/clavicle injur |
| <input type="checkbox"/> low back pain | <input type="checkbox"/> arm/elbow injury | <input type="checkbox"/> knee/thigh injury |
| <input type="checkbox"/> calcium deposits | <input type="checkbox"/> nerve damage | <input type="checkbox"/> upper back injury |
| <input type="checkbox"/> head/neck injury | <input type="checkbox"/> bone fracture | <input type="checkbox"/> wrist/hand injury |
| <input type="checkbox"/> hip/pelvis injury | <input type="checkbox"/> tennis elbow | |

If yes, please explain: _____

Are you presently receiving physical therapy? Yes No
 If yes, Therapist's Name: _____ Phone #: _____
 May we call him/her: Yes No

4. Do you have any conditions or past injuries which limit the range of motion of your muscles, joints, bones, spinal columns or any other part of your body which may be aggravated by exercise? Yes No

If yes, please explain: _____

5. Are you presently taking any medications on a regular basis? Yes No
If yes, please list all medications and dosages: _____

Are you allergic to any medications? Yes No

If yes, please list medications: _____

6. Are you presently under a doctor's care? Yes No

If yes, why? _____

Dr.'s Name: _____ Phone #: _____

May we call him/her? Yes No

7. What is your current weight? _____
What was your weight 1 year ago? _____ 5 years ago? _____ At age 20? _____

8. Are you tired or fatigued most of the day? Yes No
Are you tired or fatigued at a specific time of the day? Yes No

If yes, when: _____

On average, how much caffeine do you ingest per week? _____

On average, how much alcohol do you drink per week? _____

On average, how many times per year do you travel? _____

On average, how many hours per day do you spend at work? _____ days per week? _____

9. How would you rate the amount of physical activity you perform while at work?

very little moderate very active

little active

How would you rate the amount of physical activity you perform during leisure time?

very little moderate very active

little active

Are you presently involved in any other Physical Fitness Program Yes No

If yes, explain: _____

How physically fit do you feel presently?

unfit average very fit

below average above average

Do you feel that there are any activities which would not interest you or might cause you discomfort or pain? Yes No

If yes, specify: _____

10. What are your primary reasons for visiting the Adelphi Adult Fitness Program:

11. What is the score of your RISK FACTOR APPRAISAL? _____

I have answered the preceding questions and the RISK FACTOR APPRAISAL to the best of my ability. I have understood all the questions asked of me and have any of my concerns clarified to my satisfaction. I further understand that thorough and honest responses to these questions and the RISK FACTOR APPRAISAL are essential to my safety and prudent recommendations for the Adelphi staff.

Signature: _____ Date: _____

Witness: _____ Date: _____