active abundance
'Martial Arts Based Fitness' 'Nutrition Based Wellness'

_____/_____/ 2013

Medical History Questionnaire

General Information

Name: _____

Address: _____

Phone Number: _____ Email: _____ Birth Date: _____ Sex: ___

Family Doctor: _____ Phone Number: _____

Specialist: _____ Phone Number: _____

Name of Emergency Contact: _____

Relationship: _____ Phone Number: _____ Email: _____

Physical Measurements

- Height: _____
- Waist circumference: _____
- Blood pressure: ____/____
- Weight: _____
- Hip circumference: _____
- Pulse: _____
- BMI: _____
- Waist to hip ratio: _____
- _____

Activity History

- Do you currently have a structured exercise program? . . . . . yes no
  - If yes, please describe: _____
  - How long and how often have you been doing this program? _____
  - What are your goals in regard to this program? _____
- Are you physically active for at least 30 minutes 3 times per week? . . . . . yes no
  - If yes, please describe: _____
- Do you currently do any unstructured exercises/physical activity? . . . . . yes no
  - If yes, please describe: _____
  - How long and how often have you being doing this? _____
- Do you have a sedentary work life? (sit at computer most of day) . . . . . yes no
- Do you have a sedentary lifestyle at home? (watch tv/video games/computer) . . . . . yes no
- Are there any non-medical reasons you can't exercise regularly? . . . . . yes no
  - If yes, please describe: _____
- What exercises/physical activity/sport do you enjoy or have enjoyed previously?

_____

_____

_____

Nutrition History

- Do you currently eat according to the Canada's Food Guide? . . . . . yes no
- Do you eat a variety of foods? . . . . . yes no
- Are you currently on a 'diet'? . . . . . yes no
  - If yes, please describe: _____
- When you eat out do you try to choose the more healthy options? . . . . . yes no
- Do you drink 8-10 glasses of water everyday? . . . . . yes no

Name: _____ **Medical History Questionnaire**

Health History

- Date of last physical exam: _____
- Do you currently smoke? . . . . . yes no
  If yes, how many per day? _____
- Have you ever smoked? . . . . . yes no
  If yes, how long have you been smoke free? _____
- **Has your doctor said you have high or low blood pressure? . . . . . yes no**
- **Do you take blood pressure medication? . . . . . yes no**
- Do you or a close family member have diabetes? . . . . . yes no
  If yes, please describe: _____
- **Do you have cardiovascular problems? . . . . . yes no**
  (heart disease, previous heart attack, atherosclerosis, abnormal heart beats)
  If yes, please describe: _____
- Did a close *male blood relative* have a heart attack / surgery before the age of 55? . . yes no
- Did a close *female blood relative* have a heart attack / surgery before the age of 65? yes no
- **Has your doctor said you have high cholesterol? . . . . . yes no**
- **Do you take cholesterol controlling medication? . . . . . yes no**
- Do you have any past/current injuries or orthopedic problems? . . . . . yes no
  (back pain, knee, ankle, tendonitis, bursitis, neck, shoulder, hip)
  If yes, please describe: _____

  _____
  If yes, does it cause severe pain/discomfort or interfere with daily activities? yes no
- Do you have arthritis? . . . . . yes no
- **Do you have asthma or difficulty breathing? . . . . . yes no**
  If yes, please describe: _____
- Are you allergic to anything? (foods, plants, insects, etc.) . . . . . yes no
  If yes, please describe: _____
- Do you have medication for an allergy? . . . . . yes no
  If yes, please describe: _____
- **Do you have any other medical conditions/problems not previously mentioned? . . yes no**
  If yes, please describe: _____

If you answered 'no' to the above Health History questions, please complete a PAR-Q form.

If you answered 'yes' to any of the above Health History questions, **particularly if bolded**, please complete a PARmed-X form with your health care provider.

- **Are you pregnant or postpartum less than 6 weeks? . . . . . yes no**
  If yes, please complete a PARmed-X for Pregnancy form with your health care provider.