



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

Medical History Questionnaire

Name: _____

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.