

# HEALTH QUESTIONNAIRE for Adventure Programs

## GENERAL INFORMATION

Date _____	
First _____	Last _____
Age _____	Sex: _____
Weight: _____	Height: _____
Phone #: _____	Email: _____
Emergency contact _____	Phone # _____

## EXERCISE HISTORY

Are you presently exercising? If so, please specify activity and duration of the time per week.

Running/Jogging _____	Walking _____	Weight Training _____
Dancing _____	Swimming _____	Other _____
Racquet Sports _____	Biking _____	_____

## FAMILY DISEASE

Has your immediate family had any of the following?

_____ Heart attack or heart surgery prior to age 50	_____ Congenital heart disease
_____ Strokes prior to age 50	_____ Diabetes
_____ High blood pressure	_____ Obesity
_____ Elevated cholesterol	_____ Asthma
_____ Coronary heart disease	

## PAST MEDICAL HISTORY

Please check all that apply.

- |  |  |
|--|--|
| <input type="checkbox"/> MI, Bypass surgery or other cardiac surgery | <input type="checkbox"/> Emphysema   |
| <input type="checkbox"/> Abnormal ECG                                | <input type="checkbox"/> Unusual shortness of Breath   |
| <input type="checkbox"/> Rheumatic fever                             | <input type="checkbox"/> Lung problems   |
| <input type="checkbox"/> Heart murmur                                | <input type="checkbox"/> Joint Injury  |
| <input type="checkbox"/> Peripheral vascular disease                 | <input type="checkbox"/> Arthritis   |
| <input type="checkbox"/> Poor circulation                            | <input type="checkbox"/> Bursitis  |
| <input type="checkbox"/> Light-headedness or fainting                | <input type="checkbox"/> Back problems   |
| <input type="checkbox"/> High blood pressure                         | <input type="checkbox"/> Neck problems   |
| <input type="checkbox"/> Low blood pressure                          | <input type="checkbox"/> Shoulder problems   |
| <input type="checkbox"/> Chest discomfort                            | <input type="checkbox"/> Foot Problems   |
| <input type="checkbox"/> Strokes                                     | <input type="checkbox"/> Knee Problems   |
| <input type="checkbox"/> Diabetes                                    | <input type="checkbox"/> Any joint problems  |
| <input type="checkbox"/> Epilepsy                                    | <input type="checkbox"/> Broken bones in the past year   |
| <input type="checkbox"/> Asthma                                      | <input type="checkbox"/> Joint, muscle, ligament, and tendon sprain or strain in the past year |
| <input type="checkbox"/> Bronchitis                                  | <input type="checkbox"/> Surgery in the past year  |
|  | <input type="checkbox"/> Hernia  |

If any of the above conditions have been marked, you must have a medical doctors release to be able to participate in Aaron Ogden Person Training INC. Adventure Programs. This doctors release must accompany your health questionnaire.

## PERSONAL PRESENT INFORMATION

Please circle yes or no

- |  |   |   |
|--|---|---|
| Are you being treated for high blood Pressure?             | y | n |
| Are you experiencing chest discomfort?                     | y | n |
| Does your heart often race out of control?                 | y | n |
| Do you ever notice skipped heat beats?                     | y | n |
| Are you experiencing pain or cramping in your legs?        | y | n |
| Do you experience difficulty breathing?                    | y | n |
| Do you have shortness of breath while sitting or sleeping? | y | n |
| Are you pregnant?  | y | n |

If any of the above conditions have been marked, you must have a medical doctors release to be able to participate in Aaron Ogden Personal Training INC. Adventure Programs. This doctors release must accompany your health questionnaire.

## CORONARY RISK PROFILE

- Has your physician recently told you your cholesterol was to high?                      No                      Yes
- Have you had your cholesterol measured within the last year?                      Do not know value
- Has your physician recently told you that you have an abnormal EKG?                      No                      Yes
- Indicate your daily level of stress (circle one).  
none                      mild                      moderat@high                      extreme
- Do you smoke?                      No                      Yes
- Do you drink alcoholic beverages?                      No                      Yes
- Has your physician placed any restrictions on your activities? If yes, explain:

If any of the above conditions have been marked, you must have a medical doctors release to be able to participate in Aaron Ogden Personal Training INC. Adventure Programs. This doctors release must accompany your health questionnaire.

List any Medications/Supplements you are taking \_\_\_\_\_

List any Allergies you have \_\_\_\_\_