FITNESS CENTER
PERSONAL HEALTH ASSESSMENT

Date:__________ CSI # ________

Instructions
The health assessment questionnaire is designed to obtain information about your medical history and evaluate your current lifestyle habits. For the report to be accurate, all questions need to be answered to the best of your ability. There are no right or wrong answers. Please answer the questions in a way that best describes your current situation or health status.

Confidentiality
The personal information you share will remain confidential between you and OhioHealth.

DEMOGRAPHIC INFORMATION

Legal Name ________________________________ _________________________ _______
(Last) (First) (MI)

Preferred Name____________________________

Birth Date _____________

Gender [☐ Male ☐ Female ☐Choose Not to Disclose ☐Other_____________________________]

Address ____

Preferred Phone Number (_______) ________-________________ ☐ Cell ☐ Home ☐ Work

E-mail Address ____

Emergency Contact____

(Relationship) ____

Emergency Phone Number (_______) _________-______________ ☐ Cell ☐ Home ☐ Work

Primary Care Physician____

Have you participated in any of the following:

☐ Cardiac Rehab ☐ Pulmonary Rehab ☐ PAD Rehab

☐ ABI Program ☐ DTD Program ☐ Transitional NeuroFitness program

☐ Cancer Wellness ☐ MS Wellness

Date:______________ Name: _______________________

DOB: ________________________

HEALTH INFORMATION

Allergies:____

Are you currently pregnant? : ☐ Yes ☐ No

CARDIOVASCULAR RISK FACTORS

1. Have you ever been told your cholesterol or lipid profile was abnormal? ☐ Yes ☐ No
2. Have you ever been told you have high blood pressure? ☐ Yes ☐ No
3. Have you ever been told you have/had diabetes? ☐ Yes ☐ No

TOBACCO STATUS

1. Check the box that most accurately describes your tobacco status **(including cigarettes, e-cigarettes, pipes, cigars, and smokeless tobacco).**
   - ☐ Never smoked
   - ☐ Currently smoke cigarettes
   - ☐ Quit using tobacco more than 1 year ago.

     Quit date_______ (month/year)
   - ☐ Currently use smokeless tobacco
   - ☐ Quit using tobacco less than or equal to 1 year ago
   - ☐ If currently using, are you ready to quit?

MEDICAL CONDITIONS: Please check all apply

❒ Stroke/TIA
❒ Anorexia/Bulimia
❒ Arthritis
❒ Asthma
❒ Atrial Fibrillation
❒ Bleeding Disorders
❒ Cancer
❒ Depression
❒ Multiple Sclerosis
❒ Heart Attack
❒ Heart Valve Disease
❒ HIV Positive
❒ Seizure Disorder
❒ Congestive Heart Failure
❒ Mitral Valve Prolapse
❒ Osteoporosis/Osteopenia
❒ Aneurysm – If so, location: __________________
❒ Coronary Artery Disease
❒ Other: ___________________

PAST PROCEDURES: Please check all that apply

❒ Amputation
❒ AV Fistula
❒ AV Graft
❒ Aneurysm Repair
❒ Bone Fracture __________
❒ CABG
❒ Carotid Endarterectomy
❒ Heart Valve Surgery
❒ Colostomy/Ileostomy
❒ Defibrillator
❒ Mastectomy
❒ Gastric Bypass / Sleeve
❒ Heart Surgery
❒ Neck / Back Surgery
❒ Knee Replacement
❒ Hip Repair / Replacement
❒ Knee Arthroscopy
❒ Heart Stent / Angioplasty
❒ Lung Resection
❒ Pacemaker

MEDICATIONS

Please list any medications you currently take (do not need to include OTC and vitamins)

CURRENT HEALTH STATUS

1. Are you currently experiencing or have you experienced in the last two weeks any of the following: Chest Pain, Shortness of Breath, Dizziness. If yes, please explain.

   ____
2. Do you have any musculoskeletal concerns that may be limiting to exercise? If yes, please explain (I.e. Knee Pain, Back Pain, Fracture).

   ____

   ____

3. Do you have any balance concerns or a history of falling? if yes, please explain

   ____

LIFESTYLE HABITS

Physical Activity

Are you currently engaged in moderate physical activity 30 minutes or more 3 days a week? If so, please list current activity.

____

____

PERSONAL GOALS

List 3 goals (short or long term):

1.
____

2.
____

3.
____