GRAND VALLEY STATE UNIVERSITY

RECREATION

MEDICAL HISTORY

Name:_____ Date of Birth:_____

Gender:_____ Phone #: _____Affiliation:(circle) **Student Faculty/Staff Other**

Home Address:_____

G #: _____ Email adress: _____

Physician's Name:_____Physician's Phone #: _____

Physician's Address: _____

Emergency Contact: _____ Relation:_____

Phone #1: _____ Phone #2: _____

1. Have you ever been diagnosed or treated for any of the following heart-related problems?

	NO	YES	IF YES, WHEN/DESCRIPT
High blood pressure	☐	☐	_____
Angina (chest pain)	☐	☐	_____
Heart murmur	☐	☐	_____
Valvular heart disease	☐	☐	_____
Myocardial infarction (heart attack)	☐	☐	_____
Heart disease or problems	☐	☐	_____

Comments: _____

_____

2. Have you ever experienced any of the following signs and / or symptoms?

	NO	YES	IF YES, WHEN/DESCRIPT
Severe shortness of breath or rapid heart rate with mild or normal activity	☐	☐	_____
Ankle swelling/edema	☐	☐	_____
Severe dizziness or fainting	☐	☐	_____
Claudication or severe muscle cramps (especially in legs)	☐	☐	_____
Low blood sugar	☐	☐	_____
Long term fatigue without being sick	☐	☐	_____
Do you have any metabolic conditions	☐	☐	

Comments: _____

3. Do you have asthma or any other pulmonary problems? ☐ NO ☐ YES

Comments _____

4. Have you had any surgery as a result of an injury? ☐ NO ☐ YES

Body region and when: _____ Rehabilitation/therapy: ☐ NO ☐ YES

Comments: _____

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5. Do you have a neuromuscular disorder, rheumatoid disorder or muscular problem that is worsenedby physical activity? ☐ NO ☐ YES

If so, explain the problem, **body region affected** and **when** the pain occurs? _____

_____

6. Have any one of your parents and/or siblings been diagnosed with any of the following?

	NO	YES	Relative	Age of Onset
Heart attack/heart problems	☐	☐	_____	_____
High blood pressure	☐	☐	_____	_____
Diabetes I or II	☐	☐	_____	_____

Comments: _____

7. Do you have any medical, physical or emotional conditions (including pregnancy) which would require a modified exercise program? ☐ NO ☐ YES Comments:

_____

8. List any medications you are currently taking:

	Medication	Prescribed For	Taken Since
1.			
2.			
3.			

Comments: _____

9. Please list any food allergies or sensitivities (i.e. foods or medication): _____

10. Smoking status: ☐ Never Smoked ☐ Used to Smoke ☐ Socially ☐ Currently Smoke*

*Packs per day (amount):_____ *Number of years smoked:_____

If you quit smoking, what year did you quit? _____

Do you use cigars, hookah, pipes or smokeless tobacco products (i.e., chew, snuff)? ☐ NO ☐ YES

Have you ever been diagnosed with chronic bronchitis or emphysema: ☐ NO ☐ YES

If yes, explain: _____

11. How many days per week do you currently exercise: ☐ 6-7 ☐ 3-5 ☐ 2-1 ☐ None

How long do you typically exercise: ☐ 60+min ☐ 30+ min ☐ 20-29 min ☐ 10-19 min ☐ < 10 min

At what level or intensity do you typically exercise: ☐ Vigorous ☐ Moderate ☐ Low

12. What is the date of your last physical/check up? _____

The above stated information is true and accurate to the best of your knowledge.

Signature:_____ **Date:** _____

Office Use Only

RBP:_____/_____ CHOL: _____ Risk Level: **LR MR HR** Tech Initials:_____ Date: _____

Supervisor signiture:_____ Date:_____