GRAND VALLEY STATE UNIVERSITY
RECREATION

MEDICAL HISTORY

Name:____ Date of Birth:__________________

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. Do you experience any of the following symptoms

	NO	YES	IF YES, WHEN/DESCRIPT
Chest discomfort with exertion	☐	☐	________________________________
Unreasonable breathlessness	☐	☐	________________________________
Dizziness, fainting, blackouts	☐	☐	________________________________
Ankle swelling	☐	☐	________________________________
Unpleasant awareness of a forceful, rapid, or irregular heart rate	☐	☐	________________________________
Burning or cramping sensations in your lower legs when walking short distance	☐	☐	________________________________

Comments: ____

2. Have you performed planned, structured physical activity for at least 30 minutes at moderate intensity on at least 3 days per week for at least the last 3 months? No ☐ Yes ☐

3. Have you had in the past or currently have any of the following medical conditions?

	NO	YES	IF YES, WHEN/DESCRIPT
Heart attack	☐	☐	________________________________
Heart surgery, cardiac catheterization, or coronary angioplasty	☐	☐	________________________________
Pacemaker/implantable cardiac defibrillator/rhythm disturbance	☐	☐	________________________________
Heart valve disease	☐	☐	________________________________
Heart failure	☐	☐	________________________________
Heart transplantation	☐	☐	________________________________
Congenital heart disease	☐	☐	________________________________
Diabetes	☐	☐	________________________________
Renal disease	☐	☐	________________________________

Comments: ____

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

Comments ____

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

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

Comments: ____

6. 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? ____________________

____

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. 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? ____________________

10. 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

11. 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

Symptoms: NO (continue) YES (HCP)

Currnet activity/Medical Conditions: NO/YES (HCP) NO/NO (light-mod) YES/YES (light-mod)

HCP: YES / NO Intensity:____________ Initials:______ Date: __________

Supervisor signiture:______________________________ Date:____________________