

# Executive Health Health History Questionnaire

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Please complete the health history questions below and review the medical clearance form attached.

Check any of the following conditions that apply to you:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Heart attack, heart surgery, angioplasty, stroke   | <input type="checkbox"/> Chronic infectious disease (mono, hepatitis, HIV)  | <input type="checkbox"/> Rheumatic fever   |
| <input type="checkbox"/> Chest pain, pressure, tightness, rapid heart rate, irregular heart beats, abnormal EKG, heart palpitations | <input type="checkbox"/> Orthopedic conditions: arthritis, chronic joint pain, back injury, recent sprain or strain, muscle cramping, etc. Explain: _____<br>_____<br>_____ | <input type="checkbox"/> Asthma, bronchitis, emphysema, chronic coughing or wheezing             |
| <input type="checkbox"/> High blood pressure (> 140/90 mm/hg)   | <input type="checkbox"/> Ankle swelling   | <input type="checkbox"/> Diabetes:<br>Last time you ate: _____<br>Time/place of last shot: _____ |
| <input type="checkbox"/> Shortness of breath after mild exertion  | <input type="checkbox"/> Currently pregnant   | <input type="checkbox"/> Thyroid condition   |
| <input type="checkbox"/> Fainting or frequent dizziness   | <input type="checkbox"/> Epilepsy or convulsions  | <input type="checkbox"/> Kidney/liver problem  |
| <input type="checkbox"/> Cholesterol over 240 mg/dl   | <input type="checkbox"/> Glaucoma   | <input type="checkbox"/> Hypoglycemic (low blood sugar)  |
| <input type="checkbox"/> Smoke/chew<br>What: _____<br>How much: _____   | <input type="checkbox"/> Allergies<br>What: _____<br>_____  | <input type="checkbox"/> Blood clot:<br>Where: _____<br>Year: _____                              |

Any other conditions that might require special attention? \_\_\_\_\_  
\_\_\_\_\_

List all medications you are currently taking and what they are for: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently physically active on a regular basis? If yes, what type of activities do you engage in? How often? How long?  
\_\_\_\_\_  
\_\_\_\_\_

## Family History

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Have any immediate family members (grandparents, mother, father, sisters, brothers) experienced any of the following:

**Who?**

Heart attack or heart disease before age 55?

\_\_\_\_\_

Heart attack after age 55?

\_\_\_\_\_

Stroke before age 55?

\_\_\_\_\_

High blood pressure?

\_\_\_\_\_

Diabetes?

\_\_\_\_\_

Severe arthritis?

\_\_\_\_\_

**I hereby verify that all the questions on this form have been answered accurately and to the best of my knowledge.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_