FITNESS CENTER
PERSONAL HEALTH ASSESSMENT

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.

Date:_____ Birth Date _____ Preferred Name _____

Legal Name _____ _____ _____
(Last) (First) (MI)

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

Have you participated in any of the following:

☐ Cardiac Rehab ☐ Pulmonary Rehab ☐ PAD Rehab ☐ Cancer Wellness

☐ ABI Program ☐ DTD Program ☐ Transitional NeuroFitness program ☐ MS Wellness

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

   Quit date_____ (month/year)

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._____