SIUE CAMPUS RECREATION

Wellness Center

Health History Questionnaire

OFFICE USE ONLY
FA FC PT
Date_____
Time _____

THIS FORM MUST BE RETURNED IN PERSON. DUE TO CONFIDENTIALITY, THIS FORM CANNOT BE EMAILED.

Please respond as accurately as possible; the below information will be used to ensure a safe exercise environment. All information will remain confidential unless further professional consultation seems warranted.

Personal Information

Name _____ ID #_____ Date _____

Local Home Address _____ Primary Phone _____

City_____ State _____ Zip_____ Alternate Phone _____

Date of Birth ____/_____/_____ Age_____ Sex ❒ M ❒ F Email_____@siue.edu

Status: ❒ Student ❒ Staff ❒ Faculty ❒ Alumni ❒ Family ❒ Other: _____

Year in School: ❒ Fresh ❒ Soph ❒ Junior ❒ Senior ❒ Grad Major: _____

Emergency Contact Information

Emergency Contact _____ Phone_____

Relationship to you_____

Smoking/Tobacco Usage: ❒ Never used ❒ Smoke only on occasion ❒ Smoke up to ____ (#) (pack)/day

❒ Use different form of tobacco (cigar) (pipe) (chew) (other) ❒ Ex-Smoker (how long_____)

Alcohol Consumption: ❒ Never drink ❒ drink only on occasion ❒ _____ average drinks per week

Caffeine Consumption: ❒ Do not consume caffeinated beverages ❒ only on occasion ❒ _____average drinks per week

How often would you characterize your stress level as being high? ❒ Occasionally ❒ Frequently ❒ Constantly

---

Medical Information

How long has it been since your last physical examination?

❒ Less than 1 year ❒ 1-2 years ❒ 2-3 years ❒ 3 or more years

Do you have a personal physician? ❒ Yes ❒ No*

Personal Physician _____ Physician's Phone _____

Physician's Address _____

Do you have medical alert identification? ❒ Yes ❒ No *If yes, where is it located?* _____

*If you do not have a current physician, Health Services can provide you with a physical at a cost of $40.

Have you ever had an abnormal cholesterol reading?

❒ Yes, it was high ❒ Yes, it was low

❒ No, it was normal ❒ No, I have not had it checked or do not remember

Have you ever had an abnormal blood sugar reading?

❒ Yes, it was high ❒ Yes, it was low

❒ No, it was normal ❒ No, I have not had it checked or do not remember

Please list all medications that you are currently taking.

Name of Drug	Dosage/Frequency	Reason for Taking

Please list all vitamins, minerals or supplements that you are currently taking.

Name of Vitamin/Mineral/Supplement	Dosage/Frequency	Reason for Taking

Please list any medications that are prescribed to you that you **do not** take.

Name of Drug	Dosage/Frequency	Reason for Not Taking

Please indicate if you have had, or presently have, any of the following:

□ **I do not have any know health conditions**
□ Abnormality of heart rhythm*
□ Allergies:
_____
□ Alzheimer's
□ Amenorrhea
□ Anemia
□ Anxiety
□ Arthritis
□ Asthma*
□ Attention Deficit Hyperactivity Disorder (ADHD)
□ Autism Spectrum Disorder
□ Cancer
□ Celiac disease
□ Cerebral Palsy
□ Chronis Obstructive Pulmonary Disease*
□ Coronary Artery Disease*
□ Crohn's disease
□ Dementia
□ Depression
□ Diabetes (circle): Type I Type II
□ Disordered eating or eating disorder
□ Down Syndrome
□ Epilepsy
□ Gastroesophageal reflux disease (GERD)
□ Heart failure*
□ Hernia
□ High blood pressure
□ Hypoglycemia
□ Hypo/hyperthyroidism
□ Insomnia
□ Intestinal problems
□ Menopausal symptoms
□ Narcolepsy
□ Osteoporosis
□ Paralysis
□ Polycystic ovary syndrome (PCOS)
□ Post-COVID conditions (including "long COVID")*
□ Pregnant
□ Psychotic disorder
□ Skin problems
□ Spinal cord injury
□ Stroke
□ Ulcer
*may require medical consent as determined by the trainer

Describe any surgery that you have had within the last two years _____

_____

_____

_____

_____

Have you ever sustained any injury or experienced any type of chronic pain, which has been diagnosed as due to physical activity or sports participation? ❒ Yes ❒ No If Yes, please explain_____

_____

Do you or have you recently experienced any of the following signs or symptoms?
□ I have not experienced any of these symptoms
□ Ankle swelling
□ Burning/cramping in calves walking short distances
□ Chest discomfort with exertion
□ Dizziness
□ Fainting or blackouts
□ Cramping/numbness/tingling during exercise that is relieved with short periods of rest
□ Known heart murmur
□ Breathing discomfort when lying down
□ Pain/discomfort in the chest, neck, jaw, or arms
□ Rapid, irregular heartbeat
□ Shortness of breath at rest or with mild exertion
□ Resting heart rate over 100 beats per minute
□ Forceful, rapid, or irregular heart rate
□ Unreasonable breathlessness
□ Fatigue/shortness of breath with usual activities

Family History

Have any members of your immediate family been diagnosed with the following:

□ Heart disease
□ High blood pressure
□ Diabetes
□ High cholesterol
□ Cancer
□ Osteoporosis

Condition: _____ Condition: _____ Condition: _____
Relation: _____ Relation: _____ Relation: _____
Age of onset: _____ Age of onset: _____ Age of onset: _____

□ I am not aware of any family history of the above conditions

EXERCISE STATUS

Level of physical activity? ❒ Inactive ❒ Low (<150 min*) ❒ Medium (150-300 min*) ❒ High (>300 min*)

*number of minutes of moderate (raised heart rate) intensity activity per week

How often do you perform cardiovascular exercise for at least 20-30 minutes per session?

❒ No regular program ❒ 1 time/week ❒ 2 times/week ❒ 3-4 times/week ❒ 5 + times/week

How often do you weight train?

❒ No regular program ❒ 1 time/week ❒ 2 times/week ❒ 3-4 times/week ❒ 5 + times/week

Briefly describe your exercise program _____

_____

HEALTH GOALS

Please indicate your *top three* goals.

____ Improve strength
____ Improve muscle tone & shape
____ Improve cardiovascular fitness
____ Improve flexibility
____ Improve health
____ Other _____
____ Reduce cholesterol
____ Reduce blood pressure
____ Increase energy
____ Reduce stress
____ Prevent injury
____ Lose weight/decrease body fat
____ Gain weight
____ Improve diet/eating habits
____ Train for a sports-specific event
____ Rehabilitate injury

NUTRITION LIFESTYLE

What is your current weight? _____ lb height? ____ ft. ____ in.

What would you like to weigh? _____ lb

What is the most you ever weighed as an adult? _____ lb What is the least? _____ lb

What weight loss methods have you tried? _____

Which do you eat regularly?

❒ Breakfast ❒ Midmorning snack ❒ Lunch ❒ Afternoon snack ❒ Dinner ❒ After-dinner snack

How often do you eat out each week? _____ times

What size portions do you normally have? ❒ Small ❒ Moderate ❒ Large ❒ Extra-large ❒ Uncertain

How long does it usually take you to eat a meal? _____ minutes

Do you eat while doing other activities (e.g., watching TV, reading, working)? _____

Consent for Limited Release of Information

Campus Recreation may need to communicate with other SIUE offices on your behalf. Please initial before each of the following if you consent to the exchange of limited information. If you do not wish for any of your information to be shared, do not initial.

____ SIUE Health Service

____ Counseling Services

____ Intercollegiate Athletics

____ Mandating Official (please specify) _____

____ Other (please specify name) _____

____ Disability Support Services

____ International Student Services

You will need to sign a Release of Information Form if you wish to have additional information communicated.

THIS FORM MUST BE RETURNED IN PERSON.
DUE TO CONFIDENTIALITY, THIS FORM CANNOT BE RETURNED BY EMAILED.

INFORMATION FOR TRAINERS AND FITNESS COORDINATOR TO COMPLETE

Diagnoses*: Yes ☐ No ☐
Signs or symptoms: Yes ☐ No ☐
Client activity level: Currently active ☐ Not currently active ☐
Clearance required: Yes ☐ No ☐
Client start-level: Low ☐ Moderate ☐ High ☐

_____	_____	_____
Trainer name printed	Trainer signature	Date
_____	_____	_____
Coordinator name printed	Coordinator signature	Date