SIUe CAMPUS RECREATION

Wellness Center

Health History Questionnaire

OFFICE USE ONLY
FA FC PT
Date ______________
Time ______________

CANCELLATION POLICY:
It is my responsibility to contact the Wellness Center if I am unable to make my scheduled appointment. **Cancelling my appointment with under 24-hour notice will result in a 2-week delay in scheduling** my next appointment. A **missed appointment with no call will result in a 3-week delay in scheduling** my next appointment. If I miss two scheduled appointments, I will not be able to sign up for another one for the remainder of the semester. Campus Recreation is proud to offer this service to students, faculty, staff and alumni. Please value your scheduled appointment and show up in a timely manner. **Signature** ____

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.

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: ____________________

How did you hear about this program?

❒ Flyer ❒ Website ❒ Class ❒ Friend ❒ Tour ❒ Other: ________________________________

If part of a class assignment: Assignment Due Date: __________ Instructor: ____________________________

I would prefer to receive a reminder via ❒ Email ❒ Text (phone carrier ________________) (Standard text rates apply)

Emergency Contact ____ Phone______________________________

Relationship to you______________________ Address____

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

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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.

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

Please list all medications that you are currently taking.

Name of Drug	Dosage/Frequency	Reason for Taking
____________	____________	____________
____________	____________	____________
____________	____________	____________

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

- ❒ **Thyroid disorder**
- ❒ **Ankle swelling**
- ❒ **Epilepsy or seizures**
- ❒ **Diabetes**
- ❒ **Heart attack/heart disease**
- ❒ **Heart surgery**
- ❒ **Heart failure**
- ❒ **Heart murmur**
- ❒ **Heart valve disease**
- ❒ **Heart palpitations**
- ❒ **Chest pain**
- ❒ **Cancer**
- ❒ **Stroke**
- ❒ **Dizziness or fainting**
- ❒ **Unusual shortness of breath**
- ❒ **Recent hospitalization**
- ❒ *Chronic Bronchitis*
- ❒ *Emphysema*
- ❒ *Asthma*
- ❒ *Exercise-induced asthma*
- ❒ *Fibromyalgia*
- ❒ *Obesity*
- ❒ *High blood pressure*
- ❒ *High blood cholesterol*
- ❒ *High blood triglycerides*
- ❒ *Glucose intolerance*
- ❒ Hernia
- ❒ Back trouble
- ❒ Arthritis
- ❒ Osteoporosis
- ❒ Bone or joint problems
- ❒ Low blood pressure
- ❒ Hypoglycemia
- ❒ Hay fever/other allergies
- ❒ Emotional disorder
- ❒ Eating disorder
- ❒ Anemia
- ❒ Phlebitis
- ❒ Other:____________________

Are you, or may you be pregnant? ❒ Yes ❒ No

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________________________________

____

Has your weight fluctuated more than a few pounds? ❒ Yes ❒ No If Yes, please explain________________

____

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

	Mother	Father	Sister(s)	Brother(s)	Grandparent(s)
Heart disease	_____	_____	_____	_____	_____
Heart attack (under age 50)	_____	_____	_____	_____	_____
Heart surgery	_____	_____	_____	_____	_____
Stroke (under age 50)	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Pulmonary disease	_____	_____	_____	_____	_____
Sudden death	_____	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____	_____
High cholesterol	_____	_____	_____	_____	_____
Obesity	_____	_____	_____	_____	_____
Other:________________	_____	_____	_____	_____	_____

I hereby state that all of the above information is accurate to the best of my knowledge.

Signature ____ Date ______________________

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
____ 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
____ Other____

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
____ Disability Support Services
____ Counseling Services
____ International Student Services
____ Intercollegiate Athletics
____ Mandating Official (please specify) ______________________________
____ Other (please specify name) ______________________________

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