

MAC

Maintaining Active Citizens

Your Area Agency on Aging
Dorchester, Somerset, Wicomico, Worcester

Personal Health History Form

General Information							
Name					Date		
Address			City		State	Zip Code	
Home Phone			Work Phone				
Occupation			Employer		Email Address		
Gender:	Male	Female	DOB (dd/mm/yyyy)		Age	Current Weight	Height

Emergency Information			
Persons to be notified in case of an emergency:			
Name	Relationship	Home Number	Work Number
Name	Relationship	Home Number	Work Number

Personal Physician		
Doctors Name		Specialty
Name of Clinic	Clinic Phone Number	Fax
Clinic Address		City/State/Zip

Family History				
Have any of your primary relatives had any of the following conditions? Circle all that apply.				
Asthma	Epilepsy	High Cholesterol	Osteoporosis	Diabetes
Arthritis	Heart Disease	Angina	Stroke	Heart Attack
Cancer	Hypertension	Thyroid Disorder	Obesity	Other
Please provide explanation for any items checked above				
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Please identify any specific goals you have with respect to your exercise program.

Cardio Respiratory History

Please answer the following questions.

1. Do you experience any pain or discomfort in the chest at rest or with exertion?	Yes	No
2. Do you have a known heart murmur?	Yes	No
3. Do you have irregular heartbeats or arrhythmia?	Yes	No
4. Do you experience unexplained episodes of dizziness or fainting?	Yes	No
5. Do you have pain in the legs or arms at rest or during exercise?	Yes	No
6. Do you experience ankle edema?	Yes	No
7. Do you experience shortness of breath at rest or with mild exertion?	Yes	No
8. Do you experience unusual fatigue with daily or normal activities?	Yes	No
9. Do you smoke cigarettes or use other tobacco products?	Yes	No

Medical Conditions

Do you have asthma? If yes, please explain. _____	Yes	No
Do you have diabetes? If yes, please explain. _____	Yes	No
Do you have high blood pressure? If yes, please explain. _____	Yes	No
Do you have high cholesterol? If yes, please explain. _____	Yes	No
Do you have heart disease or any other heart problems? If yes, please explain. _____	Yes	No
Have you ever been diagnosed with cancer? If yes, please explain. _____	Yes	No
Do you have any past or current medical problems that may affect your ability to safely participate in an exercise program? If yes, please explain. _____	Yes	No

Orthopedic History

Do you have any current or past orthopedic conditions (e.g. joint injuries, pain, surgeries) that may limit or affect your ability to exercise?

Neck

Back

Shoulder

Elbow

Wrist/Hand

Hip

Knee

Ankle/Foot

If yes to any of the above, please explain in detail.

Please explain all surgical procedures you have had.

Medications

Please list all prescription and over-the-counter medications you currently use.

Name of Medication	Purpose	Dose

Please indicate any food or drug allergies that you may have.

The information I have provided in this questionnaire is true and accurate to the best of my knowledge. I understand that this information is necessary for the purpose of developing a safe and effective exercise program. The information I have provided is to remain confidential. I agree to provide updated health information when it is relevant to the ongoing efficiency of my personal exercise prescription.

Signed

Date
