opt/SENIORS Optimum Performance Training for Seniors

NASM National Academy of Sports Medicine

HEALTH & ACTIVITY QUESTIONNAIRE

Date:_____

I. PARTICIPANT INFORMATION

Last Name: _____ First Name: _____

Address: _____
number street city state zip

Email: _____

Phone: Home ( ) _____ Cell ( )_____

Birthdate: __ __/ __ __/ __ __ Age: _____ Gender: _____
mo day year

Estimated Height: _____ Estimated Weight: _____

Have you attempted to change your weight in the past year? Yes No

Primary Physician: _____
Name Phone Number

Alternate Physician: _____
Name Phone Number

II. MEDICAL HISTORY

Date of last physical exam: __ __/ __ __/ __ __

Is there a FAMILY HISTORY of fatal heart attack/sudden death?

Father	YES	NO	Age at Death: _____
Mother	YES	NO	Age at Death: _____
Brother(s)	YES	NO	Age at Death: _____
Sister(s)	YES	NO	Age at Death: _____

Are you a type 2 diabetic? YES NO Year Diagnosed: _____

Is your diabetes in control? YES NO Do you take insulin? YES NO

Do you experience hypoglycemia (low blood sugar) during or after exercise? YES NO

Do you ever experience light-headedness or blackouts during exercise? YES NO

Please check below if you currently have or have had any of the following conditions:

Angina (chest pain)	_____	Heart attack	_____
Irregular heart beat (arrhythmias)	_____	Ischemia	_____
High blood pressure	_____	Narrowing aorta	_____
High cholesterol	_____	Uncontrolled heart failure	_____
Cancer	_____	Acute pulmonary embolus	_____
Asthma	_____	Myocarditis/ pericarditis	_____
Stroke	_____	Dissecting aneurysm	_____
Acute infections	_____	Electrolyte abnormalities	_____
Thyroid Malfunction	_____	Neuromuscular disorders	_____
Musculoskeletal disorders	_____	Anemia	_____
Kidney Problems	_____	Osteoarthritis	_____
Rheumatoid Arthritis	_____	Digestive Diseases	_____

Explain any checked: _____

_____

_____

_____

List any musculoskeletal/joint issues/injuries (e.g., arthritic joints, spinal conditions):

_____

_____

_____

_____

Have you had any accidental falls in the past 12 months? YES NO

Explain: _____

_____

_____

_____

Please indicate below any medications that you are taking:

Medication/dosage: _____ Purpose:_____

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Medication/dosage: _____ Purpose:_____

Medication/dosage: _____ Purpose:_____

III. HEALTH-RELATED BEHAVIORS

Do you smoke or have you smoked in the last 6 months? YES NO

If you do smoke, indicate number of cigarettes smoked per day:

Less than 10 10-20 20-40 Over 40

How many days per week do you accumulate at least 30 minutes of physical activity?

0 1 2 3 4 5 6 7 days per week

How many days per week do you spend at least 20 minutes doing vigorous exercise?

0 1 2 3 4 5 6 7 days per week

Can you walk ~2 miles (30 minutes) briskly without stopping? YES NO

IV. OCCUPATIONAL AND RECREATIONAL ACTIVITIES AND BEHAVIORS

List your current occupations/hobbies & if they involve repetitive movement or prolonged sitting:

Activity: _____ Repetitive movements/prolonged sitting? YES NO

Activity: _____ Repetitive movements/prolonged sitting? YES NO

Activity: _____ Repetitive movements/prolonged sitting? YES NO