CENTRAL CLEMSON RECREATION CENTER

Health History Questionnaire

First Name: _____ Last Name: _____

Address: _____

City: _____ Zip: _____

Phone #_____ DOB: _____

Email: _____

Emergency Contact: _____ Phone: _____

Family Physician: _____ Phone: _____

Last date of your physical examination: _____

YES NO Have you had surgery within the last 6 months? **If yes you must have your physician sign a release form before you can participate.**

What kind of surgery did you have? _____

YES NO Do you smoke?

YES NO Do you consume alcohol?

Indicate any diseases or illnesses you have had or currently have:

☐ Asthma	☐ Allergies	☐ Arthritis
☐ Back Condition	☐ High Blood Pressure	☐ Low Blood Pressure
☐ Bursitis	☐ Fatigue	☐ Joint Pain
☐ Ulcers	☐ Heart Condition	☐ Sinus
☐ Hemorrhoids	☐ Hernia	☐ Nervous Tension
☐ Diabetes	☐ Varicose Veins	☐ Shortness of Breath
☐ Epilepsy	☐ HIV	

Are you currently taking any medication(s):

_____

Please answer to the best of your ability

YES NO

☐ ☐ Have you ever been hospitalized

☐	☐	Heart Attack or Heart Trouble
☐	☐	Chest Pain or Angina Pectoris
☐	☐	Coronary Bypass or Angioplasty
☐	☐	Abnormal Exercise Stress Test
☐	☐	Heart Murmur (suggesting a heart abnormality)
☐	☐	Irregular Heartbeat or Rhythm (suggesting a heart abnormality)
☐	☐	High Blood Pressure
☐	☐	Impaired Circulation
☐	☐	Stroke
☐	☐	Convulsions or Loss of Consciousness
☐	☐	Diabetes Mellitus
☐	☐	High Blood Cholesterol Level
☐	☐	Are you pregnant
☐	☐	Musculoskeletal Limitations of Movement
☐	☐	Difficulty Breathing/Shortness of Breath
☐	☐	Arthritis, Rheumatism
☐	☐	Knee problems
☐	☐	Hip problems
☐	☐	Shoulder problems
☐	☐	Foot problems
☐	☐	A chronic, recurrent or morning cough
☐	☐	Episodes of coughing up blood
☐	☐	Increased anxiety or depression
☐	☐	Swollen, stiff or painful joints
☐	☐	Back Pain

Please explain if you have answered YES to any of the above.

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