**Health History Form 1**

Please answer each of the questions in this inventory to the best of your ability. For each question, please mark the best choice unless otherwise indicated. In some instances, you will need to write out your response. If you need assistance with answering any of these questions, please request assistance from an MVP Professional.

General Information:

Name: ______________________________________________________________________

Gender: _____Male _____Female Birth Date: __________

Height: _____Ft.______inches Weight: __________ pounds

Address______________________________________________________________________

City: ______________________________ State: ________________ Zip: ___________

Phone: ____________________________ email: ___________________________________________

Marital Status: ______________________ Highest Level Education__________________________

Occupation: _______________________________

Primary Care Physician: __________________________________________________________

Address: ____________________________________________________________________

City: _______________________________

State:________________Zip:_____________________

Phone: _____________________________

**Part 1: Past Medical History**

1. Have you ever been told by a doctor that you have of had heart problems, an abnormal EKG, or had a heart attack of stroke?

   Y N

2. Have you ever had a coronary by-pass surgery, angioplasty, or any other type of heart surgery?

   Y N

   Have you ever had difficulty breathing or become short of breath with mild or light exertion?

   Y N

3. Do you have a history of diabetes of thyroid, kidney, or liver disease?
   Y N

   Have you ever experienced irregular heartbeat(arrhythmia) or been diagnosed with a heart condition or disease?

   Y N

4. If you answered yes to any of the above questions, please provide additional information below:

   ______________________________________________________________

   ______________________________________________________________

**Part 2: Current Medical History**

5. Do you currently experience or have any of the following?

   A. Shortness of breath with exercise?
      Y N

   B. Unexplained dizziness or fainting?
      Y N

   C. Difficulty breathing at night, except in an upright position?
      Y N

   D. Swelling in the ankles or lower extremities (other than due to an injury?)
      Y N

   E. Heart palpations (rapid or irregular heartbeat of the heart?)
      Y N

   F. Pain in the legs that may cause you to stop walking.
      Y N

G. Known heart murmur?
Y N

A. Are you pregnant or is it likely that you may become pregnant at this time?
Y N

If you are pregnant, what is the expected due date?
______________________________________

B. Have you had surgery or been diagnosed with any disease in the past three months?
Y N

C. If you answered yes, please list the date_________________________________________________

And nature of the surgery/disease:
_____________________________________________________

D. In the past 12 months, have you been told by a healthcare professional that you have an elevated cholesterol level or abnormal lipid profile, or are you on any medications to control your blood lipids?
Y N

E. Do you currently smoke cigarettes, or have you quit within the past six months?
Y N

F. Have your father or brother(s) had heart disease prior to the age of 55 or mother or sister(s) had heart disease prior to age 65?
Y N

G. Within the past 12 months, has a healthcare professional told you that you have high blood pressure? (systolic>140mmHg, diastolic >90 mmHg?)
Y N

H. Do you currently have high blood pressure, or are you taking medication(s) to manage high blood pressure?
Y N

I. Within the past 12 months, have you been told by a healthcare professional that you have an elevated fasting blood glucose level? (>100mg/dl)
Y N

J. Are you currently under the care of a healthcare professional for blood clots or other circulatory problems?
Y N

K. Do you currently experience problems or pain in your bones, joints, or

muscles that may be aggravated with exercise?
Y N

L. Do you currently experience any back and/or neck discomfort or problems?
Y N

M. Are you currently under the care of a healthcare professional for any other

health/medical problems?
Y N

N. If you answered YES to any of the questions in part 2(questions 7-19, please provide additional
information:________________________________________________________________
________________________________________________________________
________________________________________________________________

O. Please list below all prescriptions and over-the-counter medications you are currently taking.

Medicine Dosage
Frequency

________________________________________________________________
________________________________________________________________

P. Are there any medications that your physician and/or healthcare professional have prescribed for you in the past 12 months that you are currently not taking?
Y N

If you answered yes, please list the medications:
________________________________________________________________

**Part 3: Physical Activity/Exercise History**

Q. Please list any favorite activities you would like to include in your exercise plan.

________________________________________________________________

R. Please list any activities you dislike or do not want to include in your exercise plan.

________________________________________________________________

S. Please list any fitness activities (e.g., jogging, cycling, strength training that you participate in regularly (include how often, how hard, and how long.)

______________________________________________________________________

T. Please list any recreational activities (e.g. tennis, golf) that you participate in regularly(include how often)

______________________________________________________________________

U. Where do you plan to exercise (e.g., club, home, outdoors?)

______________________________________________________________________

V. If you plan to exercise at home, list all available equipment.

______________________________________________________________________

29. Have you been told by a healthcare professional that you should not exercise?
    Y N

30. If you answered YES to question #29, please provide additional information below:

**Part 4: Weight History**

31. What do you consider to be your ideal body weight?
    ____________________________________

32. What has been your lowest body weight as an adult (list how old you were?)________________

33. What has been your highest body weight as an adult (list how old you were?)________________

33. What is your current weight?
    _______________________________________________________

34. What was your weight one year ago?
    ________________________________________________

**Health History Form 3**

**Part 5: Diet/Nutrition History**

35. How many meals do you typically eat per day?

_______________________________________________

36. Do you eat a variety of foods from each of the food groups?
Y N

37. Do you try to limit the amount of fat you eat to <30% of your total caloric intake?
Y N

38. Do you use sugar sparingly by adding little or none to foods you eat and by limiting your intake of desserts, candy, and soft drinks?
Y N

39. Do you limit your alcohol consumption to 1-2 drinks or fewer per day?
Y N

40. If you answered NO to any of the questions in part 5(questions 37-40,) please describe below:

______________________________________________________________________________
______________________________________________________________________________

*I have answered the questions in this Health History Inventory to the best of my ability, and as accurately as possible. I understand that this information is kept strictly confidential and is used only for the purpose of helping the MVP professional make the most appropriate recommendations and design a safe and effective physical-activity program to meet my unique needs. Furthermore, I understand that this information cannot be released to any other party without my prior written approval in accordance with the Health Insurance Portability and Accountability Act of 1996. I understand that my failure to disclose health, medical, or related information that might affect my participation in physical activity may limit the ability of the MVP professional to provide the safest possible physical-activity program. Finally, I understand that the information collected in this Health History Inventory has been designed using the recommendations provided by the American College of Sports Medicine for risk stratification as described in their publication, ACSM's Guidelines for Exercise Testing and Prescription, 7th edition (2006.)*

Client Signature_____________________________________________________Date_____________

MVP Professional Signature____________________________________________Date________________

OPTIMIZING ATHLETES