FIT 2 THE CORE
NutritionWorks
Training * Nutrition * Education * Results

Health History Questionnaire

Name:_________________________________ Age:_____ Date of birth:_____________
First M.I Last day/month/yr

Address:____
street city state zip

Telephone (home): _____________________ (business):___________________________
Occupation:____________________ Place of Employment:__________________________
Marital Status:(circle one) SINGLE MARRIED DIVORCED WIDOWED SPOUSE:__________
Education: (check highest level) ELEMENTARY___ HIGH SCHOOL___ COLLEGE___
Personal Physician:___________________ Location:_____________________________
Physicians Number:___________________________
Reason for last doctor visit?__________________Date of last physical exam?________
What is your current weight?____________________ Height?__________________________
Have you previously been tested for an exercise program? YES___ NO___ YEAR(s)_____
Location of test:________________
Person to contact in case of an emergency:______________________________________
Phone#_________________ (relationship):____

PLEASE CHECK YES OR NO

PAST HISTORY			FAMILY HISTORY			PRESENT SYMPTOMS		
(Have you ever had?)	YES	NO	(Have any immediate family or grandparents had?)	YES	NO	(Have you recently had?)	YES	NO
High blood pressure	☐	☐	Heart attacks	☐	☐	Chest pain/ discomfort	☐	☐
Any heart trouble	☐	☐	High blood pressure	☐	☐	Shortness of breath	☐	☐
Disease of the arteries	☐	☐	High cholesterol	☐	☐	Heart palpitations	☐	☐
Varicose veins	☐	☐	Stroke	☐	☐	Skipped heart beat	☐	☐
Lung disease	☐	☐	Diabetes	☐	☐	Cough on exertion	☐	☐
Asthma	☐	☐	Congenital heart defect	☐	☐	Coughing of blood	☐	☐
Kidney disease	☐	☐	Heart operations	☐	☐	Dizzy spells	☐	☐
Hepatitis	☐	☐	Early death	☐	☐	Frequent headaches	☐	☐
Diabetes	☐	☐	Other family illness	☐	☐	Frequent colds	☐	☐
Heart murmur	☐	☐	____________________			Back pain	☐	☐
Arthritis	☐	☐	____________________			Orthopedic problems	☐	☐

(For staff)

____

____

Hospitalizations: Please list recent hospitalizations (Women: do not list normal pregnancies)

year	location	reasons

Any other medical problems/ concerns not already identified? Yes___No___(Please list below)____

____

Have you ever had your cholesterol measured? Yes___ No___
If yes, (value)_______(date)_______Where?____

Are you taking any Prescription or Non-Prescription medications? Yes___ No___ (include birth control pills)

Medication	Reason for Taking	For How Long?

Do you currently smoke? Yes___ No___ If so, what? Cigarettes____ Cigars____ Pipe____
How much per day: <.5 pack____ 0.5 to 1 pack_____ >2 packs_____
Have you ever quit smoking? Yes____ No_____ When?_____
How many years and how much did you smoke?

____

Do you drink any alcoholic beverages? Yes____ No____ If yes, how much in 1 week?
Beer_______(cans) Wine_______ (glasses) Hard liquor________ (drinks)

Do you drink any caffeinated beverages? Yes_____ No______ If yes, how much in 1 week?
Coffee_______ (cups) Tea________(glasses) Soft drinks_________ (cans)

ACTIVITY LEVEL EVALUATION

What is your occupational activity level? Sedentary___ Light___ Moderate___ Heavy___

Do you currently engage in vigorous physical activity on a regular basis? Yes____ No_____
If so, what type__________________________________How many days per week?____________
How much time per day? (check one) <15min____ 15-30min____ 30-45min____ >60min____
Do you ever have uncomfortable shortness of breath during exercise? Yes____ No____
Do you ever have chest discomfort during exercise? Yes_____ No_____
If so, does it go away with rest?________________________

Do you engage in any recreational or leisure-time physical activities on a regular basis?
Yes_____ No_____
If so, what activities?____
On average: How often?_____________times/week; For how long?__________time/session

What was your lightest weight as an adult? ___________
What was your heaviest weight as an adult? ___________

Are you currently following a weight reduction diet plan? Yes____ No____

If so, how long have you been dieting? ________months
Is the plan prescribed by your doctor? Yes_____ No______

Have you used weigh reduction diets in the past? Yes_____No_____; If yes, how often and what type?____

Please list everything you eat in one 24 hr period. Include any snacks and beverages including water intake. Be as specific as possible.

Time: Food/ Beverage:
Time: Food/ Beverage:
Time: Food/ Beverage:
Time: Food/ Beverage:
Time: Food/ Beverage:
Time: Food/ Beverage:
Time: Food/ Beverage:
Time: Food/ Beverage:

Make a list of your favorite healthy foods:
1.
2.
3.
4.
5.

Make a list of your least favorite healthy foods:
1.
2.
3.
4.
5.

Have you ever been placed on a specific nutritional program before? Yes______ No______

If so, who created it for you and what did it consist of?
____
____
____

What were your results?
____
____
____

I, __________________________, agree to allow the trainers at Fit 2 The Core/Nutritionworks to design a fitness program for me to enhance my health and fitness goals. I will follow that program to the best of my ability and I will not hold Fit 2 The Core/NutritionWorks or any of their staff personally liable for any problems, injuries or illnesses that might occur due to a sudden change in my current behavior. This weight management program does not replace the expert advice or medical treatment of my own private doctor. I have given Fit 2 The Core/NutritionWorks all necessary information about myself to prevent any possible complications.

Signature:________________________________ Date:__________________________________