UNIVERSITY OF DELAWARE
EMPLOYEE HEALTH & WELLBEING

Health History Questionnaire

Demographic Information

Name:________________________ Gender: __________ Age:__________
Department:________________________ Campus Address:________________________
Campus Phone:________________________ Email Address:________________________
Cell Phone:________________________ Home Phone:________________________

Emergency Contact Information

Campus Emergency Contact:________________________ Phone:________________
Personal Emergency Contact:________________________ Phone:________________
Primary Physician: ________________________ Phone:________________
Physician's Address: ____

Medical History

Do you have, or have you ever had, any of the following? Check Yes or No

Y	N	
☐	☐	Heart attack, heart disease
☐	☐	Chest pain with physical activity
☐	☐	Pacemaker/implantable cardiac device
☐	☐	Heart bypass surgery (CABG)
☐	☐	High blood pressure ($\geq$140/90 mm HG)
☐	☐	Rheumatic Fever
☐	☐	Extra or skipped heart beats
☐	☐	Heart murmur/click
☐	☐	Abnormal stress test
☐	☐	Stroke
☐	☐	High cholesterol (Total $\geq$200 mg/dL)
☐	☐	Type 1 Diabetes
☐	☐	Type 2 Diabetes
☐	☐	Lightheadedness/fainting
☐	☐	Frequent headaches

Y	N	
☐	☐	Unusual shortness of breath
☐	☐	Cancer
☐	☐	Arthritis
☐	☐	Joint pain
☐	☐	Back pain
☐	☐	Ruptured disc/hernia
☐	☐	Balance issues
☐	☐	Females: Are you pregnant?
☐	☐	Drug allergies
☐	☐	Asthma/Hay fever
☐	☐	Chronic cough
☐	☐	Convulsions/epilepsy
☐	☐	Other (specify)__________________
☐		None of the above

If you answered 'Yes' to any of the above, please explain in detail below (including current status, dates, and duration of treatment where applicable):

____
____
____

Current Medications that affect your ability to exercise:

____
____

Please answer the following questions to the best of your knowledge.

1. Have you, or any of your immediate family, been diagnosed with heart/artery disease?
   - ☐ I have been diagnosed with heart/artery disease
   - ☐ Immediate family member (mother, father, siblings) diagnosed younger than 50 years of age
   - ☐ Immediate family member (mother, father, siblings) diagnosed older than 50 years of age
   - ☐ No history of heart/artery disease

2. Do you Smoke? ☐ Yes ☐ No
   If yes, how many cigarettes/cigars do you smoke per day? _______
   If you have smoked in your lifetime, but do not smoke any longer, when did you quit? ___/___/____

3. What is your current physical activity level?
   - ☐ None
   - ☐ Somewhat active
   - ☐ Moderately active
   - ☐ Very active

4. If you are currently active, please describe the type of activity, duration, and frequency:
   ____
   ____
   ____

5. What are your fitness goals?
   ____
   ____
   ____

6. Please describe any **physical** limitations (injuries, chronic conditions, medications, etc.) that your trainer should be aware of when designing your program:
   ____
   ____
   ____

7. Please describe any **personal** limitations (workload, travel, family obligations, etc.) that your trainer should be aware of when designing your program:
   ____
   ____
   ____

8. What facility would you prefer to work train?
   - ☐ Employee Fitness Center
   - ☐ Personal Training Studio
   - ☐ Student Fitness Center

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125 Carpenter Sports Building

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9. What is your availability throughout the week?
   - ☐ Monday:____
   - ☐ Tuesday:____
   - ☐ Wednesday:____
   - ☐ Thursday:____
   - ☐ Friday:____

10. When do you want to start personal training? How often would you like to train?
    - ☐ Start Date:____________________________________
    - ☐ 1x a month
    - ☐ 2x a month
    - ☐ 1x a week
    - ☐ 2x a week
    - ☐ Other:____

11. **Male** or **Female**-Personal Trainer preference? (Please circle one.)

12. Please list any additional information you feel would be valuable for your trainer to know:

    ____

    ____

    ____

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