

B.A.S. Wellness

Phone: 919-624-6707

HEALTH STATUS QUESTIONNAIRE

Member Name (Please Print): _____

Date of Birth: ____ / ____ / ____ Age: _____ Gender: Male Female Phone #: _____

Emergency Contact: _____ Phone #: _____

Physician Name: _____ Phone #: _____

Fax #: _____

BOX 1

Do you have a history of the following?

Indicate when (date):

| | | |
|----------|--|--------------------|
| YES / NO | Heart attack | ____ / ____ / ____ |
| YES / NO | Heart surgery | ____ / ____ / ____ |
| YES / NO | Cardiac catheterization | ____ / ____ / ____ |
| YES / NO | Coronary angioplasty (PTCA) | ____ / ____ / ____ |
| YES / NO | Pacemaker / implantable cardiac defibrillator / rhythm disturbance | ____ / ____ / ____ |
| YES / NO | Heart valve disease | ____ / ____ / ____ |
| YES / NO | Heart failure | ____ / ____ / ____ |
| YES / NO | Heart transplantation | ____ / ____ / ____ |
| YES / NO | Congenital heart disease | ____ / ____ / ____ |
| YES / NO | Stroke | ____ / ____ / ____ |

Do you have any of the following symptoms?

YES / NO You experience chest discomfort with exertion
YES / NO You experience unreasonable breathlessness
YES / NO You experience dizziness, fainting, blackouts
YES / NO You take heart medications

BOX 2

Please mark ALL true statements

- ____ You are a man older than 45 years
____ You are a woman older than 55 years or you have had a hysterectomy or you are post menopausal
____ You smoke
____ Your blood pressure is greater than 140 / 90 mmHg or are taking blood pressure medications
____ Your blood cholesterol is greater than 240/mg/dL
____ You have a close blood relative who had a heart attack before age 55 (father or brother) or age 65 (mother or sister)
____ You are diabetic or take medicine to control your blood sugar.
____ You have been diagnosed with kidney disease
____ You have been diagnosed with thyroid or other endocrinological disorder
____ You have respiratory problems, such as, asthma, chronic bronchitis, emphysema or COPD
____ You have muscular problems which could be aggravated by physical activity
____ You have arthritis
____ You have other orthopedic problems which could be aggravated by physical activity
____ You are pregnant or have delivered within the past 8 weeks
____ You have Multiple Sclerosis

List all medications you are taking.

Medication Reason
1. _____

Medication Reason
2. _____

Medication Reason
3. _____

Medication Reason
4. _____

YES / NO I have read and understood the questions asked. I verify that all the information noted above is accurate to the best of my knowledge and I understand that it is my responsibility to update the Trainer of any changes in medical status.

Signature: _____ Date: _____

Office Use Only:
Medical Clearance Given: ___/___/___ Date of Screening: ___/___/___
Medical Clearance Rcd: ___/___/___ Date of Orientation: ___/___/___

**The Health Status Questionnaire is a way to determine your medical/health risk which will determine if a medical clearance is required.*