

# ENERJOY Health Status Questionnaire

Name: \_\_\_\_\_ Phone (H): \_\_\_\_\_  
Address: \_\_\_\_\_ Phone (W): \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_  
DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F  
Personal Physician: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_  
How did you hear about ENERJOY/Liz Bradford? \_\_\_\_\_

## Section I. Medical History

1. Mark any of the following for which you have been diagnosed and treated:

- |                                         |                                           |                                    |                                     |
|-----------------------------------------|-------------------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Kidney problem | <input type="checkbox"/> Heart problem    | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Mononucleosis  | <input type="checkbox"/> Cirrhosis, liver | <input type="checkbox"/> Stroke    | <input type="checkbox"/> Asthma     |

2. Mark any medications taken the last 6 months:

- |                                                  |                                                |                                        |                                               |
|--------------------------------------------------|------------------------------------------------|----------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Blood thinner           | <input type="checkbox"/> Epilepsy medicine     | <input type="checkbox"/> Nitroglycerin | <input type="checkbox"/> Cholesterol medicine |
| <input type="checkbox"/> Diabetes medicine       | <input type="checkbox"/> Heart rhythm medicine | <input type="checkbox"/> Insulin       | <input type="checkbox"/> Other                |
| <input type="checkbox"/> Blood pressure medicine | <input type="checkbox"/> Diuretic (water pill) | <input type="checkbox"/> Digitalis     |                                               |

3. List any surgeries you have had in the past (e.g., knee, heart, back): \_\_\_\_\_  
\_\_\_\_\_

4. Have you ever had back problems, any problems with joints (knee, hip, shoulder, elbow, neck) or been diagnosed with arthritis?

If yes, describe: \_\_\_\_\_  
\_\_\_\_\_

5. Do you have any other medical conditions or health problems that may affect your exercise plan or safety in any way?

If yes, describe: \_\_\_\_\_  
\_\_\_\_\_

## Section II: Cardiopulmonary and Metabolic Symptoms

- |   |   |                                                                                           |
|---|---|-------------------------------------------------------------------------------------------|
| Y | N | Do you ever get unusually short of breath with very light exertion?                       |
| Y | N | Do you ever have pain, pressure, heaviness or tightness in the chest area?                |
| Y | N | Do you regularly have unexplained pain in the abdomen, shoulder or arm?                   |
| Y | N | Do you ever have dizzy spells or episodes of fainting?                                    |
| Y | N | Do you ever feel "skips," palpitations or runs of fast or slow heart beats in your chest? |
| Y | N | Has a physician ever told you that you have a heart murmur?                               |
| Y | N | Do you regularly get lower -eg pain during walking that is relieved with rest?            |
| Y | N | Do you have any joints that often become swollen and painful? Where:                      |

**Section III. Cardiopulmonary/Metabolic Disease**

Y    N    Have you ever had a heart attack, bypass surgery, angioplasty or been diagnosed with coronary artery disease or other heart disease? \_\_\_\_\_ If yes, describe: \_\_\_\_\_  
\_\_\_\_\_

Y    N    Do you have emphysema, asthma or any other chronic lung condition or disease? \_\_\_\_\_  
\_\_\_\_\_

Y    N    Are you an insulin-dependent diabetic? \_\_\_\_\_  
\_\_\_\_\_

**Section IV: Coronary Risk Factor Profile**

Y    N    Have you had high blood pressure ( $\geq 140$  mmHg systolic or  $\geq 90$  mmHg diastolic) on more than one occasion? Please list any medications you take for high blood pressure: \_\_\_\_\_  
\_\_\_\_\_

Y    N    Have you ever been told that your blood cholesterol was high (200 mg/dL or higher)? Cholesterol level \_\_\_\_\_

Y    N    Do you currently smoke 10 or more cigarettes per day? cigarettes/day \_\_\_\_\_ years smoked \_\_\_\_\_

Y    N    Have you ever been told that you have high blood sugar or diabetes? \_\_\_\_\_ If yes, describe: \_\_\_\_\_  
\_\_\_\_\_

Y    N    Has anyone in your immediate family (parents, siblings) had any heart problems or coronary disease before age 55? Describe: \_\_\_\_\_  
\_\_\_\_\_

Y    N    Do you feel you are more than 20 lb overweight? What do you feel is your realistic ideal weight? \_\_\_\_\_

**Section V. Fitness**

Circle the average number of times per week you participate in planned moderate-to-strenuous exercise of at least 20 minutes duration (brisk walking, jogging, cycling, swimming, stair climbing, weight lifting, active sports such as tennis, aerobic classes, etc.).

0      1      2      3      4      5      6      7      8      9      10

Y    N    Can you briskly walk 1 mile without fatigue?

Y    N    Can you jog 2 miles continuously at a moderate pace without discomfort?

Y    N    Can you do 10 push-ups?

Please list your body weight:

Now: \_\_\_\_\_ lb/kg

1 year ago: \_\_\_\_\_ lb/kg

Age 21: \_\_\_\_\_ lb/kg