_____
Last Name

Health History Questionnaire

Name _____ Date of Birth ___ / ___ / _____ Age _____

Home Address _____

Phone (cell) _____ Phone (work/home) _____

Email Address _____

Personal Physician's Name _____ Phone _____

In Case of Emergency Contact

Contact Name _____ Relationship _____

Contact's Phone _____

Contact Name _____ Relationship _____

Contact's Phone _____

Family History – check if any of your immediate family has had:

Heart Disease: ○ parent ○ grandparent ○ sibling ○ child
Age when they first knew: ○ under 50 ○ 50-65 ○ over 65

Stroke: ○ parent ○ grandparent ○ sibling ○ child

Diabetes: ○ parent ○ grandparent ○ sibling ○ child

High blood pressure: ○ parent ○ grandparent ○ sibling ○ child

High cholesterol: ○ parent ○ grandparent ○ sibling ○ child

Additional Comments:

_____

_____

_____

_____

_____
Last Name

Personal History – check if you have had:

○ AIDS ○ Anemia ○ Arthritis ○ Asthma ○ Bronchitis/Emphysema ○ Cancer

If yes to Cancer, what kind? _____

Surgery (Type & Date) _____

Treatment (Type & Date) _____

○ Diabetes ○ Epilepsy ○ Gout ○ Heart Disease ○ Heart Murmur, skipped or rapid beats

○ High Blood Pressure ○ High Cholesterol ○ Kidney Disease ○ Lung Disease

○ Phlebitis ○ Rheumatic Fever ○ Stroke ○ Thyroid Problems

Additional Comments:

_____

_____

_____

Orthopedic Injuries or Chronic Pain:

○ Neck ○ Cervical Spine ○ Thoracic Spine ○ Lumbar Spine ○ Other

○ L shoulder ○ L elbow ○ L wrist ○ L hip ○ L knee ○ L ankle

○ R shoulder ○ R elbow ○ R wrist ○ R hip ○ R knee ○ R ankle

Please explain any of the above that you checked:

_____

_____

_____

_____

_____

Additional Comments:

_____

_____

_____

_____

_____

_____
Last Name

Medications:

Are you currently taking any prescription medications? ○ Yes ○ No

If yes, list the name(s) and dosage:

_____
_____
_____
_____
_____

Are you currently taking any over the counter medications and/or vitamins? ○ Yes ○ No

If yes, list the name(s) and dosage:

_____
_____
_____
_____
_____

Health Habits:

Do you use tobacco? ○ Yes ○ Quit ○ Never

What did/do you use? ○ Cigarettes ○ Cigars ○ Pipe ○ Chewing Tobacco

How much did/do you use a day:

_____
_____

How long have you used tobacco? _____

If you quit, how long ago? _____

_____
Last Name

Physical Activity Habits:

Do you engage in physical activity? ○ Yes ○ No

What kind?

_____

_____

How hard? ○ Light ○ Moderate ○ Hard How often? _____

What kind of exercises have you done in the past?

_____

_____

How hard? ○ Light ○ Moderate ○ Hard How often? _____

Do you work? ○ Yes ○ No

If so, how active are you at work? ○ Sedentary ○ Active ○ Heavy

Please Explain:

_____

_____

_____

Do you experience discomfort, shortness of breath, or pain with physical activity/exercise? ○ Yes ○ No

If yes, what type of activity/symptoms:

_____

_____

_____

_____
Last Name

Nutritional Habits:

Do you consider yourself overweight? ○ Yes ○ No

If yes, for how long? _____
How many meals do you typically eat per day? _____
How often do you eat outside the home? _____ per week
How much of the following do you consume?
_____ cups of caffeinated beverages per day (coffee, tea, soda, energy drinks, etc; 8oz = 1)

_____ glasses of beer per day (12oz = 1)

_____ glasses of wine per day (4oz = 1)

_____ glasses of liquor per day (1 ½ oz = 1)

_____ total alcoholic beverages per week

Stress:

Do you consider your day stressful? ○ Yes ○ No

What is the nature of your stress?

_____
_____
_____

How many hours do you sleep a night? _____ Is your sleep sound? ○ Yes ○ No

Do you practice any form of meditation? ○ Yes ○ No

If so, what kind?

_____
_____

Availability:

What days and times are you available?

○ Monday	_____	am/pm	– _____	am/pm	or	_____ am/pm	– _____ am/pm
○ Tuesday	_____	am/pm	– _____	am/pm	or	_____ am/pm	– _____ am/pm
○ Wednesday	_____	am/pm	– _____	am/pm	or	_____ am/pm	– _____ am/pm
○ Thursday	_____	am/pm	– _____	am/pm	or	_____ am/pm	– _____ am/pm
○ Friday	_____	am/pm	– _____	am/pm	or	_____ am/pm	– _____ am/pm
○ Saturday	_____	am/pm	– _____	am/pm	or	_____ am/pm	– _____ am/pm
○ Sunday	_____	am/pm	– _____	am/pm	or	_____ am/pm	– _____ am/pm

_____
Last Name

Quality of Life Questionnaire
(Pre-Survivorship Program)

1) How would you rate your overall satisfaction with life?
○ poor ○ below average ○ good ○ very good ○ excellent

2) How would you rate your current health and well being?
○ poor ○ below average ○ good ○ very good ○ excellent

3) How often do you get sick or go to the doctor?
○ once a week ○ twice a month ○ once a month ○ once every six months ○ once a year

4) How would you rate your past fitness level?
○ poor ○ below average ○ good ○ very good ○ excellent

5) How would you rate your current fitness level?
○ poor ○ below average ○ good ○ very good ○ excellent

6) How would you rate your perceived body image?
○ poor ○ below average ○ good ○ very good ○ excellent

7) How would you rate your current energy level?
○ poor ○ below average ○ good ○ very good ○ excellent

8) How would you rate your current ability to enjoy activities?
○ poor ○ below average ○ good ○ very good ○ excellent

9) How would you rate your current mobility?
○ poor ○ below average ○ good ○ very good ○ excellent

10) How would you rate your current level of pain?
○ no pain ○ manageable pain ○ chronic pain ○ unbearable pain

11) How would you rate your past eating habits?
○ poor ○ below average ○ good ○ very good ○ excellent

12) How would you rate your current eating habits?
○ poor ○ below average ○ good ○ very good ○ excellent

13) How would you rate your current ability to perform activities of daily living (bathing, grooming, dressing, cooking, cleaning…)?
○ poor ○ below average ○ good ○ very good ○ excellent

14) How would your rate your current ability to perform work-related tasks?
○ poor ○ below average ○ good ○ very good ○ excellent

15) How would you rate your sleep at night?
○ poor ○ below average ○ good ○ very good ○ excellent

16) How would you rate your current mood?
○ depressed ○ mildly depressed ○ content ○ happy ○ very happy

_____
Last Name

Medical Clearance Form

Dear Doctor,

_____ has applied for enrollment in the fitness testing and exercise programs at the YMCA of Metropolitan Columbus, GA as part of our Cancer Survivorship Program. The fitness testing program involves a sub-maximal test of cardio respiratory fitness, sit and reach flexibility test, girth measurements, postural assessments, shoulder ROM test, muscular strength and muscular endurance tests. The exercise program is designed to start with basic stretching and flexibility exercises along with the use of light resistance to increase upper and lower body strength. The program will take the client through various levels of increasing difficulty. All of our trainers are certified by the Cancer Exercise Training Institute as a Cancer Exercise Specialist. They have gone through training in working with the special needs of cancer survivors.

By completing the form below, however, you are not assuming any responsibility for our administration for the fitness testing and/or exercise programs. If you know of any medical or other reasons why participation in the fitness testing and/or exercise programs by the applicant would be unwise, please indicate so on this form. If you have any questions about the program, please do not hesitate to contact Jillian Albe with the YMCA at:

John P. Thayer YMCA
24 14th Street
Columbus, GA 31901
706-322-8269

REPORT OF PHYSICIAN

_____ I know of no reason why the applicant should not participate

_____ I believe the applicant can participate, but I urge caution because:

_____

_____

_____

_____ The applicant should not engage in the following activities:

_____

_____

_____

_____ I recommend that the participant not participate.

Physician's Name (Printed) _____

Physician's Signature _____

Date _____

Address _____

City, State, and Zip _____