CHI St. Joseph Health

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your wellness record.

Name *(Last, First, M.I.):*			**DOB:**
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Age:	**Physician:**	☐ M ☐ F	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

On most days, how many hours per day do you spend sitting while at home and/or during leisure time. This may include time spent visiting friends, reading or watching television?

☐ Less than 1 hour ☐ 1 hour ☐ 2 hours ☐ 3 hours ☐ 4 hours or more

How many days were you physically active for at least 30 minutes per day? Add up all the time you spent in any kind of activity that increased your heart rate and made you breathe hard some of the time.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Where are you most physically active? (Check all that apply)

☐ Parks/Trails ☐ Home Fitness Center ☐ School Track ☐ Work Site/Office Place
☐ Local Gyms or Fitness Centers ☐ Local Mall ☐ Neighborhood

Why do you want to participate in our Wellness Program? (Check all that apply)

☐ Convenience ☐ Price ☐ Location
☐ Family Member attends Cardiac Rehab ☐ Friend Referral ☐ Free Membership through Special Program

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit			

PLEASE CHECK YOU CURRENT OR PAST MEDICAL HISTORY:

☐ ANEMIA	☐ EPILEPSY/SEIZURES	☐ PACEMAKER
☐ ANGINA/CHEST PAIN	☐ EMOTIONAL/PSYCHOLOGICAL	☐ PREGNANT NOW
☐ ARTHRITIS	☐ HEADACHE/MIGRAINE	☐ SLEEP DIFFICULTY
☐ ASTHMA	☐ HEAD INJURY	☐ SMOKING: ___ PACKS PER DAY
☐ BACK INJURY	☐ HEARING LOSS	☐ STROKE/ TIA
☐ BLOOD CLOT/EMBOLISM	☐ HEART ATTACK/CIRCULATORY	☐ VISION LOSS
☐ BOWEL/BLADDER PROBLEM	☐ HERNIA	☐ OTHER: _____
☐ BRONCHITIS/EMPHYSEMA	☐ HIGH BLOOD PRESSURE	**RECENT CHANGES IN:**
☐ CANCER: _____	☐ INFECTIOUS DISEASE	☐ Weight
☐ COFFEE/CAFFEINE	☐ NECK INJURY	☐ Energy level
☐ DIABETES	☐ NUMBNESS/TINGLING	☐ Ability to sleep
☐ DIZZINESS/FAINTING	☐ OSTEOPOROSIS	☐ Other pain/discomfort:

HAVE YOU HAD OTHER SURGERY?

Check if you have had surgery on:

☐ ANKLE	☐ KNEE	☐ JOINT REPLACEMENT
☐ BACK	☐ NECK	☐ METAL IMPLANTS/PINS/PLATES
☐ ELBOW	☐ SHOULDER	☐ OTHER: _____
☐ HAND/WRIST	☐ PELVIS	☐ OTHER: _____
☐ HEART	☐ STOMACH	☐ OTHER: _____
☐ HIP	☐ WEIGHT LOSS SURGERY	☐ OTHER: _____

Patient Signature: _____ Date: _____