***Bay Mills Community College***

***Mukwa Health and Fitness Center***

**HEALTH HISTORY QUESTIONNAIRE**

The purpose of this questionnaire is to obtain information that will 1) assist in the development of an individualized exercise program, and 2) be incorporated into a database to assist in the provision of health and wellness activities for the Bay Mills Community College. Information obtained will be confidential. Information contained in the database may also be used to develop demographic data and to support grant applications, as well as possible research activities. Your signature indicates that you freely consent to provide and allow *Mukwa Health and Fitness Center* to utilize the requested information for the purposes described above.

*Signature of*

Participant/Parent/Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

 *Must be 18 years of age or older*

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *First Middle Initial Last*

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Street City State Zip Code*

Telephone: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender \_\_\_\_\_\_ Age\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_ /\_\_\_\_\_\_ /\_\_\_\_\_\_

Native American [ ] No [ ] Yes

Tribal Member [ ] No [ ] Yes Tribal Affiliation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Visit: 1-3 month[ ]  3-6 month [ ]  over 12 month [ ]  Reason for Visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Emergency Contact Person* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Relationship* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Telephone*: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Of Emergency Contact Person*

|  |  |  |
| --- | --- | --- |
| **PAST HISTORY** | **PRESENT HISTORY** | **FAMILY HISTORY** |
| Have you ever had? | Have you recently had? | Have any immediate family member(s) ever had? |
|  | **Yes** | **No** |  | **Yes** | **No** |  | **Yes** | **No** |
| High Blood Pressure | [ ]  | [ ]  | Chest Discomfort/Pain | [ ]  | [ ]  | High Blood Pressure | [ ]  | [ ]  |
| Any Artery Trouble | [ ]  | [ ]  | Shortness of Breath | [ ]  | [ ]  | Heart Attack | [ ]  | [ ]  |
| Artery Disease | [ ]  | [ ]  | Heart Palpitations | [ ]  | [ ]  | High Cholesterol | [ ]  | [ ]  |
| Stroke | [ ]  | [ ]  | Skipped Heart Beats | [ ]  | [ ]  | Stroke | [ ]  | [ ]  |
| Diabetes | [ ]  | [ ]  | Cough upon Exertion | [ ]  | [ ]  | Diabetes | [ ]  | [ ]  |
| Asthma | [ ]  | [ ]  | Coughing up Blood | [ ]  | [ ]  | Congenital Heart Defect | [ ]  | [ ]  |
| Kidney Disease | [ ]  | [ ]  | Dizzy Spells | [ ]  | [ ]  | Heart Operations | [ ]  | [ ]  |
| Hepatitis | [ ]  | [ ]  | Frequent Headaches | [ ]  | [ ]  | Early Death | [ ]  | [ ]  |
| Lung Disease | [ ]  | [ ]  | Frequent Colds | [ ]  | [ ]  | Other Family Illness |
| Heart Murmur | [ ]  | [ ]  | Orthopedic Problems | [ ]  | [ ]  |  |
| Varicose Veins | [ ]  | [ ]  | Unexplained Fatigue/Tiredness | [ ]  | [ ]  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| High Cholesterol | [ ]  | [ ]  | Upper Back Pain with Activity | [ ]  | [ ]  |  |
|  |  |  | Increased Sweating | [ ]  | [ ]  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  | Frequent Nighttime Awakening | [ ]  | [ ]  |  |

#

# Please briefly explain any **Yes** answers

Any other medical problems/concerns not already identified? **No**[ ]  **Yes**[ ]  If yes, please explain

Are you taking any prescription or non-prescription medications? (Include birth control pills) **No**[ ]  **Yes**[ ]

 Medication Reason for taking How long?

Hospitalizations: Please list recent hospitalizations in the past five years