Bay Mills Community College
Mukwa Health & 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?
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**	
Heart Murmur	**Orthopedic Problems**	
Varicose Veins	**Unexplained Fatigue/Tiredness**	
High Cholesterol	**Upper Back Pain with Activity**	**Other Family Illness**
	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

Bay Mills Community College
Mukwa Health and Fitness Education Center
Member Policies and Procedures and Information

I declare that I have read and understood the contents of the Mukwa Health and Fitness Center Member Policies and Procedures, and agree to comply with them

_____

Name of Participant (Please Print)

_____ Date _____

Signature of Participant

_____ Date _____

Signature of parent/guardian (if participant is under 18 years of age)

_____ Date _____

Signature of Witness (Must be 18 years of age or older)