Last Name:_____ Today's Date: _____

University of Houston
Q-Fit Advanced Assessment - Medical History Questionnaire
All information is private and confidential

Title: ___Mr. ___Ms. ___Miss ___Mrs. ___Dr. Gender: ___M ___F

Name (Last, First, MI)_____
Address _____
Number and Street City, State Zip

Phone ( ) _____ SSN _____-____-_____ DOB _____-____-_____
Email: _____

Age_____ yrs Current weight _____ lbs Current height _____ft _____in

Physician Dr._____ Phone ( )_____
Address _____
Number and Street City, State Zip

Emergency Contact
Name: _____ Phone:_____ Relationship: _____

Occupation _____ Employer _____

Family Medical History
Father: ___Alive, age: ____yrs, General health: ____excellent ____good ____fair ____poor
____Deceased, at age: ____yrs, Cause of death: _____

Mother: ___Alive, age: ____yrs, General health: ____excellent ____good ____fair ____poor
____Deceased, at age: ____yrs, Cause of death: _____

Siblings: ___No. of brothers, ____No. of sister, Age Range_____
Health problems:_____

If your parents, siblings, grandparents, aunts, uncles have had any of the following, please indicate with a check mark and comment below as needed:

____High blood cholesterol
____High blood pressure
____Diabetes
____Asthma/Hay fever
____Glaucoma
____Obesity (20 or more lbs overweight)
____Heart attack under age 50
____Stroke under age 50
____Congenital heart disease
____Heart operations
____Leukemia/Cancer under age 60

Comments_____
_____

Last Name:_____ Today's Date: _____

Present Health

(Check all those that apply. Write further comments below)

____High blood pressure (>140/90)
____Chest pain at rest
____Thumping/racing of heart at rest
____Heart skips beats/extra beats
____Ankles tend to swell
____High cholesterol (_____)
____1 or more episodes of coughing up blood
____Chronic fatigue
____Increased irritability
____Joints swollen, stiff, painful
____Leg pain after short walks
____Recent change in mole or wart
____Hands/feet often cold even in warm weather
____Stomach/GI distress (constipation, diarrhea, heartburn, ulcers, etc
____Low blood pressure (<90-70)
____Leg cramps
____Difficulty breathing
____Shortness of breath
____Out of breath while lying/sitting
____Chronic/recurring morning cough
____Anxiety/depression
____Difficulty sleeping
____Migraine/recurrent headaches
____Back pain
____Vision/hearing problems (_____)
____Men only: prostate problems

Women Only (check all that apply)

____Currently pregnant (if yes: _____ weeks)
____Taking oral contraceptives
____Menstrual problems (comment below if yes)
____Breast discharge/lumps
No. of pregnancies _____
No. of children _____
Date of last menstruation _____

Comments:_____
_____

Please indicate if you have had any history of the following conditions. If you check yes, comment below:

____Heart attack When?_____
____Heart murmur
____Diseases of the arteries
____Other heart problems
____Stroke When?_____
____Epilepsy/seizures (comment below)
____Varicose veins
____Bronchitis
____Asthma
____Pneumonia
____Other lung conditions
____Dizziness
____Chicken pox
____Arthritis in arms/legs
____Diabetes /abnormal blood sugar test
____Thyroid problems
____Jaundice/gallbladder problems
____Kidney/urinary problems
____Polio When?_____
____Blood clots
____Diphtheria
____Scarlet Fever
____Infectious Mononucleosis
____Anemia
____Nervous/emotional problems
____Measles

Comments: _____
_____

List any other medical/diagnostic tests you have had in the past 5 years:_____
_____

List any hospitalizations (include year and purpose):_____
_____

Comment on any other medical conditions not mentioned in this questionnaire? _____
_____

Last Name:_____ Today's Date: _____

Smoking

Do you currently smoke? ____Yes ____No Age started:_____yrs
How many per day? _____ ____Cigarettes___ Cigars ___Pipe
Do you use chewing tobacco? ____Yes ____No Age started: _____yrs
If you quit smoking, when was you last (month/year)? _____

Alcohol Consumption

What is your usual intake of the following alcoholic beverages?

Beer	_____none	____occasional	____often?	no. per week _____
Wine	_____none	____occasional	____often?	no. per week _____
Liquor	_____none	____occasional	____often?	no. per week _____

Body Weight

What do you consider a good weight for you? _____ lbs
What is the most you have ever weighed (not during a pregnancy)? _____ lbs at age _____
Current weight: _____ lbs. Weight 1 yr ago: _____lbs

Exercise

Are you currently involved in a regular exercise program? _____Yes _____No
Do you regularly walk or run 1 or more miles continuously? _____Yes _____No
If yes, average no. of miles walk/run per workout per day: _____
Average time per mile: _____min
Average duration of workout: _____ min
Do you lift weights? _____Yes _____No
Type of workout: _____
Average duration of workout: _____ min
Do you participate in aerobic-type classes? _____Yes _____No
Average duration of workout: _____ min
Do you participate in martial arts? _____Yes _____No
Average duration of workout: _____ min
Do you participate in any team/club sports? _____Yes _____No
If yes, description_____
Have you ever participated in fitness test? _____Yes _____No
If yes, description_____

Nutrition

List any prescribed/self-prescribed medications and dietary supplements you are taking: _____
_____
_____
List any drug or food allergies: _____

-Thank you