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**HEALTH HISTORY INVENTORY**

Name: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_ Sex: M / F

Physicians Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to Contact in case of emergency:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications, supplements, or drugs? If so, please list medication, dose, and reason.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your physician know you are participating in this exercise program?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any physical activity you do somewhat regularly.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you now have, or have you had in the past: Yes No

1. History of heart problems, chest pain, or stroke
2. Elevated blood pressure
3. Any chronic illness or condition
4. Difficulty with physical exercise
5. Advice from physician not to exercise
6. Recent surgery (last 12 months)
7. Pregnancy (now or within last 3 months)
8. History of breathing or lung problems
9. Muscle, joint, or back disorder, or any previous injury still affecting you
10. Diabetes or metabolic syndrome
11. Thyroid condition
12. Cigarette smoking habit
13. Obesity (body mass index (BMI) ≥ 30 kg/m^2)
14. Elevated blood cholesterol
15. History of heart problems in immediate family
16. Hernia, or any condition that may be aggravated by lifting weights or

other physical activity

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**EXERCISE HISTORY AND**

**ATTITUDE QUESTIONNAIRE**

Name: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

General Instructions: Please fill out this form as completely as possible. If you have any questions, DO NOT GUESS

1. Please rate your exercise level on a scale of 1 to 5 (5 indicating very strenuous) for each age range through your present age: 15-20 \_\_\_\_\_\_\_\_\_ 21-30 \_\_\_\_\_\_\_\_\_ 31-40 \_\_\_\_\_\_\_\_\_ 41-50 \_\_\_\_\_\_\_\_\_ 51+ \_\_\_\_\_\_\_\_\_

2. Were you a high school and/or college athlete?

□ yes □ no If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Do you have any negative feelings toward, or have you had any bad experience with, physical-activity programs?

□ yes □ no If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Do you have any negative feelings toward, or have you had any bad experience with, fitness testing and evaluation?

□ yes □ no If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Rate yourself on a scale of 1 to 5 (1 indicating the lowest value and 5 the highest.)

Circle the number that best applies

Characterize your present athletic ability. 1 2 3 4 5

When you exercise, how important is competition? 1 2 3 4 5

Characterize your present cardiovascular capacity. 1 2 3 4 5

Characterize your present muscular capacity. 1 2 3 4 5

Characterize your present flexibility capacity. 1 2 3 4 5

6. Do you start exercise programs but then find yourself unable to stick with them? □ yes □ no

7. How much time are you willing to devote to an exercise program? \_\_\_\_\_\_\_ minutes/day \_\_\_\_\_\_\_ days/week

8. Are you currently involved in regular endurance (cardiovascular) exercise? □ yes □ no

If yes, specify the type of exercise(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. \_\_\_\_\_\_\_ minutes/day \_\_\_\_\_\_\_ days/week

Rate your perception of the exertion of your exercise program (check the box):

□ light □ fairly light □ somewhat hard □ hard

9. How long have you been exercising regularly? \_\_\_\_\_\_\_\_\_\_ months \_\_\_\_\_\_\_\_\_\_ years

10. What other exercise, sport, or recreational activities have you participated in?

In the past 6 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the past 5 years: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Can you exercise during your work day? □ yes □ no

12. Would an exercise program interfere with your job? □ yes □ no

13. Would an exercise program benefit your job? □ yes □ no

14. What types of exercise interest you?

□ Walking □ Jogging □ Strength training

□ Cycling □ Traditional aerobics □ Racquet sports

□ Stationary biking □ Elliptical striding □ Yoga/Pilates

□ Stair climbing □ Swiming □ Other Activities

15. Rank your goals in undertaking exercise: What do you want exercise to do for you?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Use the following scale to rate each goal separately.

Not at all important Somewhat Important Extremely important

1. Improve cardiovascular fitness. 1 2 3 4 5 6 7 8 9 10
2. Lose weight/body fat 1 2 3 4 5 6 7 8 9 10
3. Reshape or tone my body 1 2 3 4 5 6 7 8 9 10
4. Improve performance for a specific sport 1 2 3 4 5 6 7 8 9 10
5. Improve moods and ability to cope with stress 1 2 3 4 5 6 7 8 9 10
6. Improve flexibility 1 2 3 4 5 6 7 8 9 10
7. Improve strength 1 2 3 4 5 6 7 8 9 10
8. Increase energy level 1 2 3 4 5 6 7 8 9 10
9. Feel better 1 2 3 4 5 6 7 8 9 10
10. Increase enjoyment 1 2 3 4 5 6 7 8 9 10
11. Social interaction 1 2 3 4 5 6 7 8 9 10

l. Other 1 2 3 4 5 6 7 8 9 10

16.By how much would you like to change your current weight? (+)\_\_\_\_\_\_\_lb (-)\_\_\_\_\_\_\_\_lb