

		<u>Have you ever had?</u>			<u>Has any immediate family (or grandparents) had?</u>			<u>Have you recently had?</u>
<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack(s)	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Discomfort?
<input type="checkbox"/>	<input type="checkbox"/>	Any Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breathe
<input type="checkbox"/>	<input type="checkbox"/>	Disease of the Arteries	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Heart Palpitations
<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Skipped Heart Beats
<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Cough on Exertion
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Coughing Up Blood
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Operation(s)	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy Spells
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Early Death	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Specify Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Treatment
<input type="checkbox"/>	<input type="checkbox"/>	Orthopedic Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other Family Issues	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
_____ Past History Score			_____ Family History Score			_____ Present Symptom Score		

		<u>Have you been diagnosed with/had:</u>	<u>If yes, please indicate when and other requested details.</u>	<u>Score</u>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type II <input type="checkbox"/> HBA1C	_____
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<u>Date and results of last reading</u>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Neuromuscular Conditions	<u>(Parkinson's, Multiple Sclerosis, etc.)</u>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking any prescription or non-prescription medication (including birth control). If yes, list:		_____
		<u>Medication</u>	<u>Reason For Taking It</u>	<u>How Long Taking It</u>
		_____	_____	_____
		_____	_____	_____
		_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had your cholesterol measured? If yes, please indicate:		_____
		Score: _____	Where: _____	When: _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had your glucose (blood sugar) measured? If yes, please indicate:		_____
		Score: _____	Where: _____	When: _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol? If yes, per week, # _____ cans of beer # _____ glasses of wine # _____ hard liquor drinks		_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you currently use tobacco? If yes, <input type="checkbox"/> cigarettes <input type="checkbox"/> cigar <input type="checkbox"/> pipe <input type="checkbox"/> chew and the # _____ each day.		_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever quit smoking? If yes, when _____? How much and # of years did you smoke? _____		_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had hospitalizations or surgeries that aren't yet listed? If yes, please describe:		_____
		_____		_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any other medical problems/concerns that have not been listed? If yes, please describe:		_____
		_____		_____

Signature _____ Date: _____

ACSM Score: _____ Total History Score: _____ Sign: _____ Date: _____
 Recommend: _____