

# WELCOME TO THE HEALTHPLEX! HEALTH HISTORY QUESTIONNAIRE



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Employee #: \_\_\_\_\_

**PROGRAM** – Please check any program that applies to you. If unsure, please ask our staff.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Aftercare           | <input type="checkbox"/> Health Improvement   | <input type="checkbox"/> Senior Health |
| <input type="checkbox"/> Cardiac Rehab       | <input type="checkbox"/> Cancer Rehab         | <input type="checkbox"/> Lung Gym      |
| <input type="checkbox"/> Cardiac Maintenance | <input type="checkbox"/> Pulmonary Rehab      | <input type="checkbox"/> Pool          |
| <input type="checkbox"/> Employee Health     | <input type="checkbox"/> Prenatal/Post-Partum | _____ (initial)                        |

## PERSONAL INFORMATION

**TODAY'S DATE** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (Home): \_\_\_\_\_ (Mobile): \_\_\_\_\_

Email Address: \_\_\_\_\_ Gender:  Male  Female

Race (optional):  White/Caucasian  Hispanic  Asian  
 Native American  Black/African American  Other

Employment Status:  Employed  Retired  Disabled

Former or current occupation: \_\_\_\_\_

Marital Status:  Single  Married  Widowed

Spouse's Name: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

## PHYSICIAN CONTACTS

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Other Physicians (include specialty): \_\_\_\_\_ Phone: \_\_\_\_\_

## HEALTH INSURANCE COMPANY

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

1. Have you had any of the following heart or blood vessel conditions?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Aneurysm               | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Implantable Defibrillator |
| <input type="checkbox"/> Angina (Chest Pain)    | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Pacemaker                 |
| <input type="checkbox"/> Angioplasty (PTCA)     | <input type="checkbox"/> Coronary Artery Disease  | <input type="checkbox"/> Pericarditis              |
| <input type="checkbox"/> Angioplasty with Stent | <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> Stroke                    |
| <input type="checkbox"/> Atrial Fibrillation    | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Other: _____              |
| <input type="checkbox"/> Blood Clots            | <input type="checkbox"/> Heart Rhythm Problems    | _____  |
| <input type="checkbox"/> Bypass Surgery (CABG)  | <input type="checkbox"/> Heart Transplant Surgery | _____  |
| <input type="checkbox"/> Cardiomyopathy         | <input type="checkbox"/> Heart Valve Problem      |  |

If yes, please explain (include dates when applicable):

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2. Do you currently have or have you ever had any of the following signs or symptoms?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Angina, Chest Pain / Pressure | <input type="checkbox"/> Swelling of Ankles     | <input type="checkbox"/> Palpitations      |
| <input type="checkbox"/> Dizziness / Fainting          | <input type="checkbox"/> Open Incision or Wound | <input type="checkbox"/> Inflamed Incision |
|  | <input type="checkbox"/> Shortness of Breath    | <input type="checkbox"/> Leg Pain          |

3. Do you have or have you ever had any of the following medical conditions?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Osteoarthritis       |
| <input type="checkbox"/> Back Pain            | <input type="checkbox"/> Fibromyalgia            | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Bone or joint issues | <input type="checkbox"/> Gastroesophageal Reflux | <input type="checkbox"/> Parkinson's Disease  |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cerebral Palsy       | <input type="checkbox"/> Multiple Sclerosis      | <input type="checkbox"/> Urinary Problems     |
| <input type="checkbox"/> Chronic Fatigue      | <input type="checkbox"/> Muscular Dystrophy      | <input type="checkbox"/> Other: _____         |

If yes, please explain (include dates when applicable):

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4. Has a doctor told you that you have diabetes?  Yes  No

If yes, do you take insulin?  Yes  No

Do you check your blood sugar levels?  Yes  No

Last A1c: \_\_\_\_\_ Date: \_\_\_\_\_

5. Do you have any of the following pulmonary (lung) illnesses?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Emphysema          | <input type="checkbox"/> Pulmonary Hypertension |
| <input type="checkbox"/> Bronchiectasis | <input type="checkbox"/> Lung Cancer        | <input type="checkbox"/> Pulmonary Fibrosis     |
| <input type="checkbox"/> Bronchitis     | <input type="checkbox"/> Pleurisy           | <input type="checkbox"/> Sinusitis              |
| <input type="checkbox"/> COPD           | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Sleep Apnea            |
| <input type="checkbox"/> Cor Pulmonale  | <input type="checkbox"/> Pulmonary Embolism | <input type="checkbox"/> Tuberculosis           |

Oxygen use: \_\_\_\_\_liters/minute \_\_\_\_\_hours/day Select uses:  Daytime  Night  With Activity

Type of home system: \_\_\_\_\_ Type of portable: \_\_\_\_\_ Continuous Flow or Pulsed

6. Do you have problems sleeping at night?  Yes  No

If yes, please explain (include dates when applicable):

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Do you feel rested?  Yes  No

7. Have you ever smoked cigarettes, cigars, pipes, or used chewing tobacco?  Yes  No

Average number of packs per day: \_\_\_\_\_

Would you like assistance to quit?  Yes  No

Does anyone in your household smoke?  Yes  No

8. Please check if the following apply to you:

You are a man older than 45 years

You are a woman older than 55 years, have had a hysterectomy or are postmenopausal

You smoke or quit smoking within the previous six months

Your blood pressure is greater than 140/90 mm Hg

You do not know your blood pressure

You take blood pressure medication

Your cholesterol level is greater than 200 mg/dl

You do not know your cholesterol level

You have a close blood relative who had a heart attack or heart surgery before age 55 (father or brother) or age 65 (mother or sister)

You are physically inactive (less than 30 minutes of physical activity on at least three days a week)

You are greater than 20 pounds overweight

9. Please select any of the following conditions experienced by your immediate blood relatives:

Diabetes  High Blood Pressure  High Cholesterol  Stroke

10. How would you rate your stress / anxiety level?  Low  Average  High

Would you like to speak to a staff nurse about anxiety concerns?  Yes  No

11. Do you feel safe at home?  Yes  No

Would you like to speak to a nurse about safety concerns?  Yes  No

12. Have you fallen within the last 30 days or do you fall often?  Yes  No

*Members are expected to provide their own attendant to assist with mobility needs while visiting or working out at the Healthplex. Please discuss with our exercise staff if this is an issue for you.*

13. **PAIN:** Are you having pain at this time?  Yes  No

Location & Description: \_\_\_\_\_

Have you experienced pain or discomfort during exercise in the past?  Yes  No

If yes, please explain:

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14. Please name all of your medications, their dosages, and how often you take them:  
(example: Zocor, 5 mg, 1 time a day):

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15. Allergies (include medication allergies):

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16. Physical injuries / limitations: \_\_\_\_\_

Select mobility aids you use:

Cane  Wheelchair  Walker  Crutches  Braces  Other \_\_\_\_\_

17. Past surgeries (include dates):

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18. Do you have any of the following problems that might affect your learning?  Yes  No

Visual  Hearing  Reading  Speech  Learning

19. Please list other issues we should know about that might affect treatment and/or progress  
(i.e., language barriers, cultural or religious beliefs, scheduling or transportation needs)

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## 20. PERSONAL FITNESS GOALS AT THE HEALTHPLEX

### Cardiovascular Fitness Goals

- Improve endurance of the heart and lungs
- Rehabilitation from heart surgery/procedure
- Improve activities of daily living \_\_\_\_\_

*(Please list specific activities you would like to improve)*

### Strength Fitness Goals

- Physical independence
- Improve posture
- Reshape or tone body (improve muscular endurance)
- Injury prevention or rehabilitation or joint replacement issues
- Increase size of muscles or increase amount of weight lifted (improve strength)
- Improve sports/activity performance \_\_\_\_\_

*(Sport(s) / Activity)*

- Increase bone density (osteoporosis issues)

### Additional Goals

- |  |   |
|--|---|
| <input type="checkbox"/> Improve flexibility           | <input type="checkbox"/> Prepare for childbirth (i.e., strengthen back, etc.) |
| <input type="checkbox"/> Improve diet/eating habits    | <input type="checkbox"/> Osteoporosis issues                                  |
| <input type="checkbox"/> Decrease body fat/weight loss | <input type="checkbox"/> Other _____  |