Central Oregon Community College
Exercise Physiology Lab
Medical History Form

All information is private and confidential

Date ______________

Name _______________________________________________

Address _________________________________________________

City __________________ State __________ Zip _____________

Age _______ Height _______ Weight _______ Date of Birth ________

Phone - Home _______ Work _______ Cell _______

Email Address ___________________________________________

Emergency Contact ______________________ Phone ____________

How did you hear about our program? ____________________________

What would you like to gain from this test? _______________________

Assess your health status by marking all true statements:

History

I have had:

[ ] Heart attack

[ ] Coronary Artery Bypass Grafting

[ ] Cardiac Catheterization

[ ] Angioplasty (PTCA), Coronary Stent(s)

[ ] Pacemaker/Implantable cardiac defibrillator

[ ] Heart Arrhythmia

[ ] Heart Valve disease/defect

[ ] Stroke

[ ] Heart Failure

[ ] Heart Transplant

[ ] Congenital Heart Disease

Symptoms

[ ] I experience chest discomfort with exertion.

[ ] I experience chest discomfort at rest.

[ ] I experience unreasonable breathlessness.

[ ] I experience dizziness, fainting, or blackouts.

[ ] I take heart medication(s).
Other heath issues

_______ I have diabetes.
_______ I have asthma or other lung disease.
_______ I have burning or cramping sensations in my lower legs when walking short distances.
_______ I have musculoskeletal problems that limit my physical activity.
_______ I have concerns about the safety of exercise.
_______ I am pregnant.
_______ I take the prescription medication(s) listed here:
________________________________________________________________________
________________________________________________________________________

** If you marked any of these statements in this section, consult your physician or other appropriate health care provider before engaging in physical exercise. You may need to be tested at a facility such as a hospital that monitors your heart rhythm or electrocardiogram.

Cardiovascular Risk Factors

_______ I am a man older than 45 years.
_______ I am a woman older than 55 years
_______ I am a woman who has had a hysterectomy, or am postmenopausal.
_______ I smoke or I quit smoking within the previous 6 months.
_______ My blood pressure is ≥140/90 mmHg.
_______ I do not know my blood pressure.
_______ I take blood pressure medication(s).
_______ I have a total blood cholesterol level of >200 mg/dL.
_______ I do not know my blood cholesterol level.
_______ I take blood cholesterol medication(s).
_______ I 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).
_______ I am physically inactive, therefore I exercise <30 minutes on at least 3 days per week.
_______ I am >20 pounds overweight.

Please explain any other significant medical problems that you consider important for us to know, for example HIV +, Hepatitis…
________________________________________________________________________
________________________________________________________________________

Are you currently involved in a regular exercise program? _________________
Average number of hours per week ____________
What activities do you participate in?
________________________________________________________________________
________________________________________________________________________

THANK YOU!