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MEDICAL HISTORY QUESTIONNAIRE

ILEA Students

This is your medical history form, to be completed prior to your first training session. All information will be kept confidential in accordance with the rules and exceptions provided by HIPAA or other federal and/or state laws. This information will be used for the evaluation of your health and readiness to begin our exercise program and also to treat you in cases of medical emergencies. The form is extensive, but please try to make it as accurate and complete as possible. Please take your time and complete it carefully and thoroughly, and then review it to be certain you have not left anything out.

If you have questions or concerns, we will help you with those after this form is completed. We realize that some parts of the form will be unclear to you. Do your best to complete the form. Your questions will be thoroughly addressed afterwards. It might be helpful for you to keep a written list of questions or concerns as you complete the medical history form.

Name: _____

Date: _____

MEDICAL HISTORY AND SCREENING FORM

General Information

Student:

Name _____

Address _____

Contact phone numbers _____

Birth date _____

Family Physician and/or Primary Health Care Provider:

Doctor/Other _____ Phone _____

Address _____ City _____

May I send a copy of your consultation to your physician or primary health care provider and consult with them as necessary?

☐ Yes ☐ No

Signature: _____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Sex:

☐ Male ☐ Female

Employing Law Enforcement Agency:

Position _____ Employer _____

Address _____

Phone _____

Contact Person: _____

Present Medical History

Check those questions to which you answer yes (leave the others blank).

- ☐ Has a doctor ever said your blood pressure was too high?
- ☐ Do you ever have pain in your chest or heart?
- ☐ Are you often bothered by a thumping of the heart?
- ☐ Does your heart often race?
- ☐ Do you ever notice extra heartbeats or skipped beats?
- ☐ Are your ankles often badly swollen?
- ☐ Do cold hands or feet trouble you even in hot weather?
- ☐ Has a doctor ever said that you have or have had heart trouble, an abnormal electrocardiogram (ECG or EKG), heart attack or coronary?
- ☐ Do you suffer from frequent cramps in your legs?
- ☐ Do you often have difficulty breathing?
- ☐ Do you get out of breath long before anyone else?
- ☐ Do you sometimes get out of breath when sitting still or sleeping?
- ☐ Has a doctor ever told you your cholesterol level was high?
- ☐ **Has a doctor ever told you that you have an abdominal aortic aneurysm?**
- ☐ **Has a doctor ever told you that you have critical aortic stenosis?**

Comments: _____

_____

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Do you now have or have you recently experienced:

- ☐ Chronic, recurrent or morning cough?
- ☐ Episode of coughing up blood?
- ☐ Increased anxiety or depression?
- ☐ Problems with recurrent fatigue, trouble sleeping or increased irritability?
- ☐ Migraine or recurrent headaches?
- ☐ Swollen or painful knees or ankles?
- ☐ Swollen, stiff or painful joints?
- ☐ Pain in your legs after walking short distances?
- ☐ Foot problems?
- ☐ Back problems?
- ☐ Stomach or intestinal problems, such as recurrent heartburn, ulcers, constipation or diarrhea?
- ☐ Significant vision or hearing problems?
- ☐ Recent change in a wart or a mole?
- ☐ Glaucoma or increased pressure in the eyes?

- ☐ Exposure to loud noises for long periods?
- ☐ An infection such as pneumonia accompanied by a fever?
- ☐ Significant unexplained weight loss?
- ☐ A fever, which can cause dehydration and rapid heart beat?
- ☐ A deep vein thrombosis (blood clot)?
- ☐ A hernia that is causing symptoms?
- ☐ Foot or ankle sores that won't heal?
- ☐ Persistent pain or problems walking after you have fallen?
- ☐ Eye conditions such as bleeding in the retina or detached retina?
- ☐ Cataract or lens transplant?
- ☐ Laser treatment or other eye surgery?

Comments: _____

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Women only answer the following. Do you have:

- ☐ Menstrual period problems?
- ☐ Significant childbirth - related problems?
- ☐ Urine loss when you cough, sneeze or laugh?

Date of the last pelvic exam and / or Pap smear _____

Comments: _____

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Are you on any type of hormone replacement therapy?_____

Men and women answer the following:

Are you undergoing any sex change or gender reassignment surgery or therapy? ☐ Yes ☐ No

If "Yes", describe current stage of surgery or therapy as well as future medical needs to complete same: _____

_____

_____

List any prescription medications you are now taking: _____

_____

_____

List any self-prescribed medications, dietary supplements, or vitamins you are now taking: _____

_____

_____

Date of last complete physical examination: _____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Date of last chest X-ray:_____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Date of last electrocardiogram (EKG or ECG): _____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Date of last dental check up: _____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

List any other medical or diagnostic test you have had in the past two years: _____

_____

_____

List hospitalizations, including dates of and reasons for hospitalization: _____

_____

_____

List any drug allergies: _____

_____

_____

Past Medical History

Check those questions to which your answer is yes (leave others blank).

- ☐ Heart attack if so, how many years ago? _____
- ☐ Rheumatic Fever
- ☐ Heart murmur
- ☐ Diseases of the arteries
- ☐ Varicose veins
- ☐ Arthritis of legs or arms
- ☐ Diabetes or abnormal blood-sugar tests
- ☐ Phlebitis (inflammation of a vein)
- ☐ Dizziness or fainting spells
- ☐ Epilepsy or seizures
- ☐ Stroke
- ☐ Diphtheria
- ☐ Scarlet Fever
- ☐ Infectious mononucleosis
- ☐ Nervous or emotional problems
- ☐ Anemia
- ☐ Thyroid problems
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Asthma

- ☐ Abnormal chest X-ray
- ☐ Other lung disease
- ☐ Injuries to back, arms, legs or joint
- ☐ Broken bones
- ☐ Hepatitis
- ☐ Angina
- ☐ Kidney disease
- ☐ Sleep apnea
- ☐ Jaundice or gall bladder problems

Comments: _____

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_____

Family Medical History

Father:

☐ Alive Current age _____

My father's general health is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Reason for poor health: _____

☐ Deceased ☐ Age at death _____

Cause of death: _____

Mother:

☐ Alive Current age _____

My mother's general health is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Reason for poor health:_____

☐ Deceased ☐ Age at death _____

Cause of death: _____

Siblings:

Number of brothers _____ Number of sisters _____ Age range _____

Health problems _____

Familial Diseases

Have you or your blood relatives had any of the following (include grandparents, aunts and uncles, but exclude cousins, relatives by marriage and half-relatives)?

Check those to which the answer is yes (leave other blank).

- ☐ Heart attacks under age 50
- ☐ Strokes under age 50
- ☐ High blood pressure
- ☐ Elevated cholesterol
- ■ Diabetes
- ☐ Asthma or hay fever
- ☐ Congenital heart disease (existing at birth but not hereditary)
- ☐ Heart operations
- ☐ Glaucoma
- ☐ Obesity (20 or more pounds overweight)
- ☐ Leukemia or cancer under age 60

Comments: _____

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Mental Health

Please answer the following questions truthfully whether or not you have sought professional help or treatment.

Check those to which the answer is yes (leave others blank).

- ☐ Has mental or emotional stress ever been a problem for you?
- ☐ Do you ever feel depressed for a period of two weeks or longer?
- ☐ Do you suffer from anxiety or panic attacks?
- ☐ Do you have problems with eating or with appetite?
- ☐ Do you experience uncomfortable bouts of crying from time to time?
- ☐ Have you ever attempted suicide?
- ☐ Have you ever seriously though about hurting yourself?
- ☐ Do you have trouble sleeping?
- ☐ Have you ever experienced memory loss or unexplained confusion?
- ☐ Have you ever consulted a counselor, psychologist, or psychiatrist?

Comments: _____

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Miscellaneous Health Matters

Please describe any other health related matters that may not have been addressed by the questions above.

Comments: _____

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