Health History Questionaire

Name (Please Print) ____ **Phone #** __________________________

Date of Birth ____/____/______ **Height** _________________ **Weight** ______________ **Gender** **M** **F**

Emergency Contact (Please Print): ___________________________ **Phone #** _________________________

BOX 1

Do you have a history of the following?

YES / NO Heart attack

YES / NO Heart surgery

YES / NO Cardiac catheterization

YES / NO Coronary angioplasty (PTCA)

YES / NO Pacemaker / implantable cardiac defibrillator / rhythm disturbance

YES / NO Heart valve disease

YES / NO Heart failure

YES / NO Heart transplant

YES / NO Congenital heart disease

Do you have any of the following symptoms?

YES / NO You experience chest, neck, jaw pain or discomfort that is cardiac in nature

YES / NO You experience unusual shortness of breath with usual activities

YES / NO You experience dizziness, fainting, lightheadedness or blackouts

YES / NO You take heart medications

BOX 2

Please mark ALL true statements

_______You are a male older than 45 years

_______You are a woman older than 55 years or you have had a hysterectomy or you are post menopausal

_______You smoke

_______Your blood pressure is greater than 140 / 90

_______You take blood pressure medication

_______Your blood cholesterol is greater than 200 mg / dL or HDL < 35 mg/dL

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

_______You are diabetic

_______You are physically inactive (you get less than 30 minutes of physical activity on at least 3 days/week)

_______You are 20 pounds or more overweight

_______You have been diagnosed with kidney disease

_______You have been diagnosed with thyroid or other endocrinological disorder

_______You have respiratory problems, such as asthma, chronic bronchitis, emphysema or COPD

_______You have muscular problems

_______You have arthritis or other orthopedic problems or have had a previous injury

_______You are pregnant

BOX 3

Please mark ALL true statements

_______ I do not know my blood pressure

_______ I do not know my cholesterol level

List all medications you take on a regular basis:

Medication Reason

1. ____

2. ____

3. ____

4. ____

Other Comments/Health Issues?

____

____

____

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I understand that I may be undergoing physical exertion while participating in services and activities at or associated with the Boston College Recreation Center and I certify that my level of physical fitness is sufficient for the activities in which I choose to take part. In acknowledging that I am aware of and willing to assume the risks associated with these activities and services, I hereby voluntarily agree to waive, hold harmless and indemnify the Trustees of Boston College and its agents, volunteers and employees from any and all claims demands, damages and causes of action of any nature whatsoever arising out of ordinary negligence which I, my heirs, my assigns or successors may have against them for, on account of, or by reason of my voluntary participation in services and activities at or associated with the Boston College Recreation Center. I understand the content of this document, and I execute this INFORMED CONSENT AND WAIVER OF CLAIM FORM of my own free will and accord.

Name of Participant (Print): ____

Signature of Participant: ____Date:_____________________

Signature of Parent or Guardian (If under 18 years of age): ____

YES / NO I have read and understood the questions asked. I verify that all the information noted above is accurate to the best of my knowledge.

Signature: ____ Date: ___________________________