COLORADO MESA UNIVERSITY
MONFORT FAMILY HUMAN PERFORMANCE LAB
Medical/Health Questionnaire
Please Print

PERSONAL INFORMATION

Name: _____ Date: _____

Age: _____ Sex: ☐ Male ☐ Female

RACE OR ETHNIC BACKGROUND

☐ White, not of Hispanic origin ☐ American Indian / Alaskan Native ☐ Asian
☐ Black, not of Hispanic origin ☐ Pacific Islander ☐ Hispanic

SYMPTOMS OR SIGNS SUGGESTIVE OF DISEASE (please check box if answer is "yes")

☐ 1. Have you experienced unusual pain or discomfort in your chest, neck, jaw, arms, or other areas that may be due to heart problems?

☐ 2. Have you experienced unusual fatigue or shortness of breath at rest, during usual activities, or during mild-to-moderate exercise (e.g., climbing stairs, carrying groceries, brisk walking, cycling)?

☐ 3. Have you had any problems with dizziness, fainting, or passing out DURING or AFTER exercise?

☐ 4. When you stand up, or sometimes during the night while you are sleeping, do you have difficulty breathing?

☐ 5. Do you suffer from swelling of the ankles (ankle edema)?

☐ 6. Have you experienced an unusual and rapid throbbing or fluttering of the heart?

☐ 7. Have you experienced severe pain in your leg muscles during walking?

☐ 8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:
☐ High blood pressure ☐ A heart murmur ☐ High Cholesterol
☐ A heart infection ☐ Kawasaki disease ☐ Other:_____

☐ 9. Has a doctor ever ordered a test for your heart? (for example, ECG/EKG, echocardiogram)

☐ 10. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?

☐ 11. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?

☐ 12. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?

☐ 13. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?

CHRONIC DISEASE RISK FACTORS (please check box if answer is "yes")

☐ 14. Are you a male over age 45 years, or a female over age 55 years, or a female who has experienced premature menopause and is not on estrogen replacement therapy?

☐ 15. Has your father or brother had a heart attack or died suddenly of heart disease before age 55 years; has your mother or sister experienced these heart problems before age 65 years?

☐ 16. Are you a current cigarette smoker?

☐ 17. Has a doctor told you that you have high blood pressure (more than 140/90 mm Hg), or are you on medication to control your blood pressure?

☐ 18. Is your total serum cholesterol greater than 240 mg/dl, or has a doctor told you that your cholesterol is at a high-risk level?

☐ 19. Do you have diabetes mellitus?

☐ 20. Are you physically inactive and sedentary (little physical activity on the job or during leisure time)?

☐ 21. During the past year, would you say that you experienced enough stress, strain, and pressure to have a significant effect on your health?

MEDICAL HISTORY

22. Please check which of the following conditions you have had or now have. Also check medical conditions in your family (father, mother, brother(s), sister(s)). **Check as many as apply.**

Personal	Family	Medical Condition
☐	☐	Coronary heart disease, heart attack, coronary artery surgery
☐	☐	Angina
☐	☐	High blood pressure
☐	☐	Peripheral vascular disease
☐	☐	Phlebitis or emboli
☐	☐	Other heart problems (specify: _____)
☐	☐	Lung cancer
☐	☐	Breast cancer
☐	☐	Prostate cancer
☐	☐	Colorectal cancer (bowel cancer)
☐	☐	Skin cancer
☐	☐	Other cancer (specify: _____)
☐	☐	Stroke
☐	☐	Chronic obstructive pulmonary disease (emphysema)
☐	☐	Pneumonia
☐	☐	Asthma
☐	☐	Bronchitis
☐	☐	Diabetes mellitus
☐	☐	Thyroid problems
☐	☐	Kidney disease
☐	☐	Liver disease (cirrhosis of the liver)
☐	☐	Hepatitis
☐	☐	Gallstones / gallbladder disease
☐	☐	Osteoporosis

☐	☐	Arthritis
☐	☐	Gout
☐	☐	Anemia (low iron)
☐	☐	Bone fracture
☐	☐	Major injury to foot, leg, knee, hip, or shoulder
☐	☐	Major injury to back or neck
☐	☐	Stomach / duodenal ulcer
☐	☐	Rectal growth or bleeding
☐	☐	Cataracts
☐	☐	Glaucoma
☐	☐	Hearing loss
☐	☐	Depression
☐	☐	High anxiety, phobias
☐	☐	Substance abuse problems (alcohol, other drugs, etc.)
☐	☐	Eating disorders (anorexia, bulimia)
☐	☐	Problems with menstruation
☐	☐	Hysterectomy
☐	☐	Sleeping problems
☐	☐	Allergies
☐	☐	Any other health problems (please specify, and include information on any recent illnesses, hospitalizations, or surgical procedures).

_____

MEDICATIONS

23. Please check any of the following medications you currently take regularly. Also give the name of the medication.

Medication	Name of Medication
☐ Heart medicine	_____
☐ Blood pressure medicine	_____
☐ Blood cholesterol medicine	_____
☐ Hormones	_____
☐ Birth control pills	_____
☐ Medicine for breathing / lungs	_____
☐ Insulin	_____
☐ Other medications for diabetes	_____
☐ Arthritis medicine	_____
☐ Medicine for depression	_____
☐ Medicine for anxiety	_____
☐ Thyroid medicine	_____

☐ Medicine for ulcers _____

☐ Painkiller medicine _____

☐ Allergy medicine _____

☐ Other (Please specify) _____

PHYSICAL FITNESS, PHYSICAL ACTIVITY / EXERCISE

24. In general, compared to other persons your age, rate how physically fit you are:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Not at all Physically Fit — Somewhat Physically fit — Extremely Physically fit

25. Outside of your normal work or daily responsibilities, how often do you engage in exercise that at least moderately increases your breathing and heart rate and makes you sweat, for at least 20 minutes (such as brisk walking, cycling, swimming, jogging, aerobic dance, stair climbing, rowing, basketball, racquetball, vigorous yard work)

☐ 5 or more times per week ☐ 3-4 times per week ☐ 1-2 times per week ☐ Less than 1 time per week ☐ Seldom or never

26. How much hard physical work is required on your job?

☐ A great deal ☐ A moderate amount ☐ A little ☐ None

27. How long have you exercised or played sports regularly?

☐ I do not exercise regularly ☐ Less than 1 year ☐ 1-2 years ☐ 2-5 year ☐ 5-10 years ☐ More than 10 years

SUBSTANCE USE

28. Have you smoked at least 100 cigarettes in your entire life?

☐ Yes ☐ No

29. How would you describe your cigarette smoking habits?

☐ Never smoked

☐ Used to smoke How many years has it been since you smoked? _____ years

☐ Still smoke How many cigarettes a day do you smoke on average? _____ Cigarettes/day

30. How many alcoholic drinks do you consume? (A "drink" is a glass of wine, a wine cooler, a bottle/can of beer, a shot glass of liquor, or a mixed drink)

☐ Never use alcohol ☐ Less than 1 per week ☐ 1-6 per week ☐ 1 per day ☐ 2-3 per day ☐ More than 3 per day

31. Any additional information we should know about your medical history?