# Health Questionnaire

Personal Assessment

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Murphy METs Programme

**Name:**_______________________________________________ **Date of Birth:**_________________

**Address:**________________________________________________________________________

**Email:**______________________________________________ **Mobile:**_____________________

This form is intended to obtain relevant information about your health that will assist Marie in helping you with your training programme. Please answer all questions to the best of your knowledge.

## 1. Weight

What is your current body weight? ____________

☐ Underweight (more than ½ stone under ideal)

☐ Normal (+ or – ½ stone of ideal)

☐ ½ stone to 1 ½ stone overweight

☐ More than 2 stone overweight

## 2. Blood Pressure

Do you have high blood pressure? Yes ☐ No ☐

Have you had high blood pressure in the past? Yes ☐ No ☐

Are you on medication for high blood pressure? Yes ☐ No ☐

## 3. Do you have a history of any of the following?

Heart disease Yes ☐ No ☐

Heart attack Yes ☐ No ☐

Stroke Yes ☐ No ☐

Elevated cholesterol Yes ☐ No ☐

Elevated triglycerides Yes ☐ No ☐

Any other vascular condition Yes ☐ No ☐

Do you have a history of Cancer? Yes ☐ No ☐ if so, which type:_______________________

## 4. Lifestyle Factors (non-diet related)

Are you a smoker? Yes ☐ No ☐

If so, how many per day, and, for how many years? _______/day for _______years

Are you a former smoker? Yes ☐ No ☐

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Do you currently exercise on a regular basis? Yes ☐ No ☐

If so, describe your regular exercise routine (type of exercise, how long, times per week etc.):

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

**5. Health History**
Have you ever had any of the following conditions? (Check mark in the box indicates yes, please check all that applies).

| | |
|---|---|
| ☐ Diabetes | ☐ Asthma |
| ☐ Overactive thyroid gland | ☐ Epilepsy |
| ☐ Underactive thyroid gland | ☐ Arthritis |
| ☐ Kidney disease | ☐ Osteoporosis |
| ☐ Liver disease | ☐ Prostatitis |
| ☐ Cushing's syndrome | ☐ Gout |
| ☐ Pancreatic disease | ☐ Multiple sclerosis (MS) |
| ☐ Gall bladder disease | ☐ Lung disease (ex.emphysema) |
| ☐ Parkinson's disease | ☐ Dementia |
| ☐ Other: ________________________________ | |

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**6. Stress**
What level of stress do you routinely deal with? (0 = no stress, 10 = maximum stress)

0 1 2 3 4 5 6 7 8 9 10

**7. Family History**

Have any of your blood relatives had heart disease, heart surgery, or angina? Yes ☐ No ☐

**8. Orthopedic Problems**

Do you have any serious orthopedic problems that would prevent you from exercising? Yes ☐ No ☐

If yes, please explain______________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

**9. Other problems**:

Do you have any reason to believe you should not exercise? Yes ☐ No ☐

If yes, please explain______________________________________________

______________________________________________

______________________________________________

**10. Medication**:

Please list any medications you presently take.

______________________________________________

______________________________________________

______________________________________________

**11. Wellness Goals**

Indicate which health and fitness goals interest you:

- ☐ Weight management
- ☐ improved fitness
- ☐ increased strength and muscle mass
- ☐ Advice on proper, balanced nutrition
- ☐ advice on disease prevention
- ☐ anti-aging strategies
- ☐ rehabilitation of a muscle or joint injury
- ☐ supplementation advice based on my specific needs
- ☐ Other:

______________________________________________

**12. Emergency**

Please list a relative whom we may contact in case of an emergency.

Name______________________ Telephone: ______________________

Relation: ______________________________________________