UNB EST. 1785 Fredericton

UREC UNIVERSITY OF NEW BRUNSWICK

# APEX
# Health Questionnaire

All documentation is kept confidential and will not be disclosed without your written consent.

Name:________________________________ Date:________________________

Address: ___________________________________________________________

Phone Number: (H): ________________ (W): _______________ (C): ____________

Email: ________________________________

Date of Birth: __________________ Age: ______

Goals hope to achieve from AXON Program: _______________________

_____________________________________________________________________

**Personal Health History – Please check off any that may apply:**

| | | | |
|---|---|---|---|
| Allergies | ☐ | Heart Disease | ☐ |
| Alzheimer's Disease | ☐ | Heart Palpitations | ☐ |
| Anxiety | ☐ | Hypertension (High Blood Pressure) | ☐ |
| Asthma | ☐ | Hypotension (Low Blood Pressure) | ☐ |
| Arthritis: | | | |
| Rheumatoid | ☐ | Joint Replacement | |
| Osteoarthritis | ☐ | Specify: _____________ | ☐ |
| Blood Clots | ☐ | Migraines | ☐ |
| Bursitis | ☐ | Multiple Sclerosis | ☐ |
| Cancer | ☐ | Osteoporosis | ☐ |
| Type:____________ | | | |
| Cholesterol (high) | ☐ | Parkinson's | ☐ |
| Chronic Cough | ☐ | Scoliosis | ☐ |
| Depression | ☐ | Shortness of Breath | ☐ |
| Diabetes | ☐ | Smoke | ☐ |
| | | ________ per day | |
| Dizziness/Fainting | ☐ | Stress | ☐ |
| Emphysema | ☐ | Stroke | ☐ |
| Fibromyalgia | ☐ | Date:__________ Affected side: _______ | |
| Fractures | ☐ | Tendonitis | ☐ |
| Location:_________ | | | |
| Headaches | ☐ | Thyroid Dysfunction | ☐ |
| Heart Condition | ☐ | Other: ______________ | ☐ |
| Specify: ____________ | | ______________ | |

Please list any surgeries you have had in the past, including dates:___________________

_________________________________________________________________________

Current Medications: ______________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Additional Health Information: ______________________________________________

_________________________________________________________________________

**Physical Fitness, Physical Activity/Exercise History**

Have you exercised in the past?  Briefly explain: ________________________________

_________________________________________________________________________

Signature: ______________________________  Date: ___________________________

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