UNIVERSITY OF NEW BRUNSWICK
REDS
RECREATION

Health History Questionnaire

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

Name: _____ Date:_____

Address: _____

Phone Number: (H): _____ (W): _____(C): _____

Email: _____ Occupation: _____

Date of Birth: _____ Age: _____Family Doctor: _____

Were you referred to this program? ☐ YES By Whom: _____ ☐ NO

Reason(s) for joining this exercise program:

_____

Present/Past Health History

Have you had, or do you presently have any of the following? Check all that apply.

Allergies ☐
Anaemia ☐
Anxiety ☐
Asthma ☐
Arthritis ☐
Blood Clots ☐
Bursitis ☐
Cancer ☐
Type: _____
Cholesterol (High) ☐
Chronic Cough ☐
Depression ☐
Diabetes (Pre) ☐
Diabetes (T1DM) ☐
Diabetes (T2DM) ☐
Dizziness/Fainting ☐
Fibromyalgia ☐
Fractures ☐
Location: _____
Headaches ☐
Heart Disease ☐
Heart Palpitations ☐
Hypertension ☐
Hypotension ☐
Hepatitis ☐
Joint Replacement ☐
Specify: _____
Kidney Disease: ☐
Lung Disease: ☐
Osteoporosis ☐
Osteoarthritis ☐
Parkinson's Disease ☐
Pneumonia ☐
Scoliosis ☐
Shortness of Breath ☐
Smoke ☐
Stress ☐
Swelling ☐
Tendonitis ☐
Thyroid Dysfunction ☐
Other: ☐
Specify: _____

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

_____

_____

Current Medications:

_____

_____

_____

Any Additional Health Information:

_____

_____

Physical Fitness, Physical Activity/Exercise History

Have you exercised in the past? Briefly explain: _____

_____

What forms of exercise do you enjoy the most? The least? _____

_____

Do you have specific health/fitness goals you want to achieve? _____

_____

_____

Signature: _____ Date: _____