**HEALTH & FITNESS SURVEY QUESTIONNAIRE EXAMPLE**

**There are five categories for determining health/fitness status.**

**State of Being**

Includes when your last physical examination. This information should include your physician’s name and phone number. This section will ask questions about the subject’s sex, age, height and weight.

**Sample Questions**

* When was your last physical examination? (check appropriate box)
* Within six months (acceptable)
* Within one year (acceptable)
* Has been over one year (unacceptable)
* What is your physician’s name and phone number? (optional)
* Sex: Male or Female?
* Age: Male>40 Female >50
* What is your present height?
* What is your present weight?

**Family History**

The sections include questions regarding your family history. Typical questions are about heart disease, blood press, stroke and diabetes.

* Has one or more close family member(s) been diagnosed with coronary heart disease?
* Has one or more close family member(s) been diagnosed with high blood pressure/hypertension?
* Has one or more close family member(s) suffered a stroke?
* Has one or more close family member(s) been diagnosed with diabetes mellitus?

**General Health**

This section asks specific information regarding your health. Typical questions may include whether you’re taking medications, your blood pressure. There are questions about cholesterol levels existing. This section may also includes questions about stress related symptoms, and other past issues.

* How would you describe your health?
* Good Average Poor Good with medical management and /or medications
* Is your resting blood pressure greater than or equal to 140/90 mm Hg (140 systolic pressure/90 diastolic pressure)?
* Is your blood serum cholesterol level >200mb/dL?
* Has your physician determined your cholesterol/HDL ratio?
* Have you been diagnosed with CHD?
* Have your suffered a stroke?
* Do you suffer from any stress-related symptoms?
* Extreme nervousness
* Problems sleeping
* Problems maintaining weight
* A consistently high resting heart rate
* Have you experienced any of the following symptoms in the past month?
* Chest pains when physically inactive or when physically active
* Shortness of breath climbing a flight of stairs
* Dizziness when rising from bed or a chair or anytime throughout the day
* A loss of consciousness
* Have you been diagnosed with diabetes mellitus?

**Special Health Considerations**

This section includes questions about surgeries and other conditions such as: pregnancy, muscular dystrophy, nerve or sensory damage and multiple sclerosis. They are also asking about orthopedic conditions and medications.

* Have you had any surgeries within the past year?
* If so, please state reason
* Do you have any of the following limiting physical conditions?
* Pregnancy
* Muscular dystrophy
* Nerve or sensory damage
* Multiple sclerosis
* Other
* Do you suffer from any of the following orthopedic conditions?
* Arthritis
* Bursitis
* Broken bones
* Stress fractures
* Prosthesis (hip, knee replacement, etc.)
* Other
* Are you on any of the following medications?
* Heart medications
* Hypertensive medications
* Asthma medications
* Insulin injections
* Water pills
* Other

**Environmental and Lifestyle Factors**

This section determines how active you are, you’re eating and living habits such as smoking and drinking.

* Do you tend to eat meals high in dietary fat?
* Are you sedentary (do not exercise at all)?
* Do you exercise less than three to five times per week on a regular basis?
* How would you describe your fitness ability?
* Do you sleep less than six hours per night?
* Do you drink more than two glasses of alcohol per day?
* Do you currently smoke cigarettes?
* Were you a heavy smoker who recently quit?