



One minute resting heart rate = _____ beats/minute

HEALTH RISK APPRAISAL

Name _____ Age _____
Mailing Address _____ Phone _____
Primary Health Care Provider _____ Provider's Phone _____
In case of emergency, contact _____ Phone _____

Health History

Date of last physical/medical examination _____

Please list medications (prescription, over-the-counter, dietary supplements) taken regularly and the reason for taking:

- 1 _____ reason _____
- 2 _____ reason _____
- 3 _____ reason _____

Please list any drug allergies _____

- 1. Do you use tobacco products? _____ If yes, how much? _____
- 2. Has your doctor ever said your blood pressure was too high or too low? _____
- 3. Have you (or a family member) ever been told that you have diabetes? _____
- 4. Do you have any known cardiovascular problems (abnormal ECG, previous heart attack, atherosclerosis, etc.)? _____ If yes, explain _____
- 5. Has your doctor ever told you your cholesterol level was high? _____
- 6. Do you have any injuries or orthopedic problems (bursitis, bad back, bad knees, arthritis, etc.)? _____ If yes, explain _____
- 7. Are you pregnant or post-partum less than six weeks? _____
- 8. Do you have any other medical conditions or problems not previously mentioned?

9. Are you currently involved in a regular exercise program? _____ If yes, explain:

Nutrition Information

Body Weight

- | | YES | NO | EXPLAIN |
|---|-------|-------|--------------|
| 10. I am at or within ten pounds of my desired weight. | _____ | _____ | _____ |
| 11. I am trying to lose weight (describe method of wt loss) | _____ | _____ | _____ |
| 12. Indicate what you consider a good weight for yourself: | _____ | _____ | _____ pounds |

General Eating Patterns (Check all that apply)

13. On most days of the week, I
- | | |
|---|---|
| _____ Eat three meals throughout the day | _____ Snack late in the evening |
| _____ Snack frequently or eat on the run | _____ Eat four to six small meals a day |
| _____ Skip breakfast and eat a big dinner | _____ Go to fast food chains to eat |

ISU WELLNESS CENTER

Department of Health & Nutrition Sciences • Kasiska College of Health Professions

Reed Gym #205A, phone – 282-2117, wellness@isu.edu; <http://isu.edu/wellness>**Typical Nutrition Choices (Indicate your usual consumption)**Meat, poultry, fish, dry beans, eggs, and nuts group*(Example: one serving = 2-3 oz of cooked lean meat = one egg = 1/2 cup cooked beans)***Red Meat**

_____ None _____ 1 serving/day _____ 2-3 servings/day _____ 4+ servings/day

Poultry and Fish

_____ None _____ 1 serving/day _____ 2-3 servings/day _____ 4+ servings/day

Milk, yogurt, and cheese group*(Example: one serving = 1 cup of milk = 1 cup of yogurt = 1 1/2-2 oz cheese = 1/2 cup ice cream)***Dairy products**

_____ None _____ 1 serving/day _____ 2-3 servings/day _____ 4+ servings/day

Type of products (check all that apply)

_____ whole _____ 1-2% milk _____ skim/non-fat _____ soy

Vegetable group (include vegetable juice)*(Example: one serving = 1/2 cup raw or cooked vegetables = 3/4 cup juice)*

_____ None _____ 1-2 servings/day _____ 3-5 servings/day _____ 6+ servings/day

Fruit group (include fruit juice)*(Example: one serving = 1/2 cup raw or canned fruit = 3/4 cup juice = 1 medium fruit)*

_____ None _____ 1 serving/day _____ 2-4 servings/day _____ 5+ servings/day

Bread, Cereal, Rice, & Pasta group*(Example: one serving = 1 slice of bread = 1 oz of cereal = 1/2 cooked pasta or rice)*

_____ None _____ 1-5 servings/day _____ 6-11 servings/day

MiscellaneousNumber of **servings per day** you usually consume:

Regular or diet soda _____ 0-1 _____ 2-3 _____ 4-5 _____ 6+

Coffee/Tea _____ 0-1 _____ 2-3 _____ 4-5 _____ 6+

Chocolate/Sweets/Chips _____ 0-1 _____ 2-3 _____ 4-5 _____ 6+

Alcoholic Beverages _____ 0-1 _____ 2-3 _____ 4-5 _____ 6+

14. How many glasses of water do you drink per day? (1 glass = 8 oz)

_____ 0-3 glasses _____ 4-5 glasses _____ 6-8 glasses _____ 9+ glasses

Physical Activity

15. How would you describe your current fitness level?

_____ Below average _____ Average _____ Above average _____ Outstanding

16. Are you currently involved in a regular exercise program? _____ YES _____ NO

*If YES, go to questions 17 - 20.**If NO, go to question 21.*

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17. If **YES** to 16, indicate the main reason why you exercise (Select only one)
- | | |
|--|--|
| <input type="checkbox"/> It makes me feel good. | <input type="checkbox"/> It is good for my health. |
| <input type="checkbox"/> I'm trying to lose weight. | <input type="checkbox"/> I am required to exercise |
| <input type="checkbox"/> My doctor told me to exercise | <input type="checkbox"/> Other _____ |

18. If **YES** to 16, indicate the number of days per week you participate in the following activities?
- | | |
|---|---|
| <input type="checkbox"/> Walking/Running | <input type="checkbox"/> Group Fitness (i.e. step, yoga, cardio-tone) |
| <input type="checkbox"/> Tennis | <input type="checkbox"/> Stationary cycling (upright, recumbent) |
| <input type="checkbox"/> Swimming | <input type="checkbox"/> Bicycling (outdoor) |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Stairmaster |
| <input type="checkbox"/> Handball/Racquetball | <input type="checkbox"/> Other(s) _____ |
| <input type="checkbox"/> Weight lifting | |

19. If **YES** to 16, how many minutes per day do you usually spend in exercise?
- | | |
|---|---|
| <input type="checkbox"/> 10 minutes or less | <input type="checkbox"/> 30 – 45 minutes |
| <input type="checkbox"/> 10 – 20 minutes | <input type="checkbox"/> 45 – 60 minutes |
| <input type="checkbox"/> 20 – 30 minutes | <input type="checkbox"/> 60 minutes or more |

20. If **YES** to 16, on a scale of 0 (very, very easy) – 10 (very, very hard), how would you describe the level of difficulty of your workouts? _____

21. If **NO** to 16, indicate the main reason why you don't exercise (Select only one)
- | | |
|--|--|
| <input type="checkbox"/> Not enough time/too busy | <input type="checkbox"/> Not motivated |
| <input type="checkbox"/> Don't know how to use equipment | <input type="checkbox"/> Don't have access to facilities |
| <input type="checkbox"/> No one to exercise with | <input type="checkbox"/> Other _____ |

(Please check one) Upon request, the Wellness Center will provide follow-up consultations and information pertaining to your fitness testing results.

- YES, I am interested in a follow-up consultation and additional information.
 NO, I am not interested in a follow-up consultation at this time.

Consent Form

I acknowledge, to the best of my ability, that I am in good health and have no known medical problems that would restrict my ability to participate in an exercise program or undergo exercise testing procedures.

Signature _____ Date _____

LAB PERSONNEL ONLY: Reviewed by _____ Date reviewed _____

Comments:

PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU TO YOUR APPOINTMENT!