ILLINOIS STATE UNIVERSITY
DEPARTMENT OF RECREATION SERVICES
Health Screening

Name______________________________________ Date_____________________

Sex M____ F____ Address____

Email Address____

Phone (Day)__________________________(Evening)_____________________________

Age______ Birth Date________________

Physician's Name________________________ Phone #____________________________

Person to Contact in case of emergency___________________________________Phone#________________

Health History

Are you taking any medications supplements or drugs? If yes, please explain and identify:

____
____
____

Which of these exercises are you now doing? (circle)

None Walk Bike Swim Aerobics Run/Jog

Housework Cross country Ski Stairmaster Precor Other_______

How many days per week do you exercise? (circle)
1 2 3 4 5 6 7

How much time per day to you exercise? (circle)
0-15 min. 15-30 min 30-45 min 45-60 min more than 60 min.

Describe and explain your daily routine of physical activity:

____
____
____
____

Do you now, or have you had in the past: (if so, please explain) Yes No

1. History of heart problems, chest pain or stroke ___ ___
____
____

2. Increased blood pressure ___ ___
____
____

3. Any Chronic illness or condition ___ ___
____
____

	Yes	No
4. Difficulty with physical exercise	___	___
5. Advice from physician not to exercise	___	___
6. Recent surgery (last 12 months)	___	___
7. Pregnancy (now or within last 3 months)	___	___
8. History of breathing or lung problems	___	___
9. Muscle, joint, or back disorder, or any previous injury still affecting you	___	___
10. Diabetes or thyroid condition	___	___
11. Cigarette smoking habit	___	___
12. Increased blood cholesterol	___	___
13. History of heart problems	___	___
14. Hernia, or any condition that may be aggravated by lifting	___	___
15. Fainting, lightheadedness or blackouts	___	___
16. Sever or recurrent headaches	___	___
17. Eating Disorder	___	___

Signature:_______________________________ **Date:**_____________