# Humboldt State University Health and Wellness Institute Medical Information and History and Release of Liability

Name Address

Home Phone

Work Phone

Age \_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex

*The following questions are designed to help us tailor the health and fitness assessment and follow-up counseling to your personal situation. It is extremely important for us to know if you have any medical conditions which may affect your testing process or your progress in our program. Please take the time to answer these questions accurately.*

# Medical History

**YES NO** In the past five years have you had:

( ) ( ) 1. Pain or discomfort in chest, neck, jaw, or arms

( ) ( ) 2. Shortness of breath or difficulty breathing at rest or with mild exertion (e.g., walking) ( ) ( ) 3. Dizziness or fainting

( ) ( ) 4. Ankle edema (swelling)

( ) ( ) 5. Heart palpitations (forceful or rapid beating of heart) ( ) ( ) 6. Pain, burning, or cramping in leg with walking

( ) ( ) 7. Heart murmur

( ) ( ) 8. Unusual fatigue with mild exertion

Have you ever had:

( ) ( ) 9. Heart disease, heart attack, and/or heart surgery ( ) ( ) 10. Abnormal EKG

( ) ( ) 11. Stroke

( ) ( ) 12. Uncontrolled metabolic disease (e.g., diabetes, thyrotoxicosis, or myxedema) ( ) ( ) 13. Asthma or any other pulmonary (lung) condition

( ) ( ) 14. Heart or blood vessel abnormality (e.g., suspected or known aneurysm) ( ) ( ) 15. Liver or kidney disease

( ) ( ) 16. Are you currently under the care of a physician?

( ) ( ) 17. Do you currently have an acute systemic infection, accompanied by a fever, body aches, or swollen lymph glands?

( ) ( ) 18. Do you have a chronic infectious disease (e.g. mononucleosis, hepatitis, AIDS)? ( ) ( ) 19. Do you have a neuromuscular, musculoskeletal, or rheumatoid disorder that is

made worse by exercise?

( ) ( ) 20. Do you have an implantable electronic device (e.g. pacemaker)?

( ) ( ) 21. Do you know of any reason why you should not do physical activity?

**If you answered yes to any of these questions, please explain.**

**Risk Factors**

**YES NO DON’T KNOW**

( ) ( ) ( ) 1. Are you a male 45 years of age or older? ( ) ( ) ( ) 2. Are you a female 55 years of age or older

( ) ( ) ( ) 3. Do you have a father or brother who had a heart attack or heart surgery before age 55?

( ) ( ) ( ) 4. Do you have a mother or sister who had a heart attack or heart

surgery before age 65?

( ) ( ) ( ) 5. Do you smoke or have you quit in the past 6 months?

( ) ( ) ( ) 6. Do you have frequent secondhand smoke exposure?

( ) ( ) ( ) 7. Do you know your blood pressure? / mmHg-Date: ( ) ( ) ( ) 8. What is your total cholesterol? mg/dL-Date:

( ) ( ) ( ) 9. Are you taking cholesterol lowering medication?

( ) ( ) ( ) 10. Do you know your HDL cholesterol? mg/dL-Date: ( ) ( ) ( ) 11. Is your HDL cholesterol > 60mg/dL?

( ) ( ) ( ) 12. What is your fasting blood glucose? mg/dL – Date: ( ) ( ) ( ) 13. Do you exercise regularly? If so, explain.

**If you answered yes to any of these questions, please explain.**

Office Use

BMI\_\_\_\_\_ SBP\_\_\_\_\_ DBP\_\_\_\_\_ TC\_\_\_\_\_ LDL\_\_\_\_\_ HDL\_\_\_\_\_ FBG\_\_\_\_\_

Family History\_\_\_\_\_ Smoking\_\_\_\_\_ Sedentary\_\_\_\_\_

# Health-Related Questions

**YES NO**

( ) ( ) 1. Are you pregnant?

( ) ( ) 2. Are you allergic to isopropyl alcohol (rubbing alcohol) or latex?

( ) ( ) 3. Do you have any allergies to medications, bees, foods, etc.? If so please list

( ) ( ) 4. Do you have any skin problems?

( ) ( ) 5. Do you have any other medical condition(s)/surgeries?

( ) ( ) 6. Have you had any caffeine, food, or alcohol in the past 3 hours? ( ) ( ) 7. Have you exercised today?

( ) ( ) 8. Are you feeling well and healthy today?

( ) ( ) 9. Do you have any other medical concerns that we should be aware of?

**If you answered yes to any of these questions, please explain.**

## Medications

Please Select Any Medications You Are Currently Using:

|  |  |
| --- | --- |
| * Diuretics | * Other Cardiovascular |
| * Beta Blockers | * NSAIDS/Anti-inflammatories (Motrin, Advil) |
| * Vasodilators | * Cholesterol |
| * Alpha Blockers | * Diabetes/Insulin |
| * Calcium Channel Blockers | * Birth Control |
| * Other Drugs (record below) |  |

Please list the specific medications that you currently take:

**Have you been participating in weightlifting consistently three times a week over the last two years? If so, what exercises are performed in your workout program?**

**I certify that the information I have provided is complete and accurate to the best of my knowledge.**

Date

Signature of Subject

Date

Signature of Witness

## Office Use Only

**Low Risk Moderate Risk High Risk**

HUMBOLDT STATE UNIVERSITYRELEASE OF LIABILITY, PROMISE NOT TO SUE, ASSUMPTION OF RISK AND AGREEMENT TO PAY CLAIMS

# I have read this form, and I understand the test procedures that I will perform and the attendant risks and discomforts. Knowing these risks and discomforts and having had an opportunity to ask questions that have been answered to my satisfaction, I consent to participate in this test.

In consideration for being allowed to participate in this Activity, on behalf of myself and my next of kin, heirs and representatives, I **release from all liability and promise not to sue** the State of California, the Trustees of The California State University, California State University, Humboldt State University and their employees, officers, directors, volunteers and agents (collectively “University”) from any and all claims, **including claims of the University’s negligence,** resulting in any physical or psychological injury (including paralysis and death), illness, damages, or economic or emotional loss I may suffer because of my participation in this Activity, including travel to, from and during the Activity.

I am voluntarily participating in this Activity. I am aware of the risks associated with traveling to/from and participating in this Activity, which include but are not limited to physical or psychological injury, pain, suffering, illness, disfigurement, temporary or permanent disability (including paralysis), economic or emotional loss, and/or death. I understand that these injuries or outcomes may arise from my own or other’s actions, inaction, or negligence; conditions related to travel; or the condition of the Activity location(s). **Nonetheless, I assume all related risks, both known or unknown to me,**

## of my participation in this Activity, including travel to, from and during the Activity.

I agree to **hold** the University **harmless** from any and all claims, including attorney’s fees or damage to my personal property that may occur as a result of my participation in this activity, including travel to, from and during the Activity. If the University incurs any of these types of expenses, I agree to reimburse the University. If I need medical treatment, I agree to be financially responsible for any costs incurred as a result of such treatment. I am aware and understand that I should carry my own health insurance.

Date: Signature of Subject:

Date: Signature of Witness: