



## LIFESTYLE & HEALTH QUESTIONNAIRE

Fitness Appraisal, Inc.

[fitnessappraisal.com](http://fitnessappraisal.com)

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Once you have completed the blood profile (phase 1) of the wellness screening program you will be participating in a confidential health/fitness assessment. Be sure you write down the date and time of your evaluation in your calendar.

Please complete this Lifestyle and Health Questionnaire. You need to bring this completed form to your health/fitness screening appointment.

The confidential evaluations will be conducted by Bob Antonacci, MSED Exercise Physiologist and Advanced Cardiac Life Support Certification. Bob has 25 years experience in administering wellness/fitness programs. Bob was also a two-time All American Wrestler at Iowa State University and broke the Guinness Book of World Records for most push-ups in 30 minutes, 1,630. At the end of the evaluation (approx. 90 minutes) you will receive a computerized report of your results and wellness recommendations (diet and exercise) coupled with a consultation.

### The Evaluation Will Consist Of The Following:

- Resting Heart Rate & Blood Pressure & Body Weight
- Body Composition Analysis- Skinfolds
- Hydrostatic Weighing
- Waist Measurement
- Modified Sit & Reach and Back Flexibility Assessment
- Maximum Push-ups
- Two Minute Abdominal Curls
- Vertical Jump
- Lung Capacity
- Grip Strength
- Sub-Maximal 9 Lead EKG Monitored Treadmill Exercise Test



Please wear shorts or light sweat pants, T-shirt and jogging or walking shoes. Public safety employees participating in the hydrostatic weighing need to bring a towel and bathing suit.

***Eat a light breakfast and/or lunch, DO NOT drink coffee, energy drinks or use tobacco for 3 hours prior to your evaluation. Be sure to maintain your current medication schedule.***

# RISK STRATIFICATION

Please read the following questions carefully and answer each one honestly. This information will be kept strictly confidential.

Name \_\_\_\_\_ Height \_\_\_\_\_ Date \_\_\_\_\_  
 Age \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

**PLEASE LIST MEDICATIONS:** \_\_\_\_\_

YES	NO	<b>TABLE 1: Please check "Yes" or "No" if you have experienced during the past year the following symptoms:</b>
		1. Chest pain or discomfort in the chest, neck, jaw, arms or other areas during rest and/or physical activity?
		2. Shortness of breath at rest or with mild exertion?
		3. Dizziness, faint or general lapse of consciousness?
		4. Difficulty breathing while sleeping which is relieved by sitting on the side of the bed or by getting out of bed?
		5. Ankle edema or swelling (most evident at night)?
		6. Rapid regular or irregular heart actions, palpitations or sudden increased heart rate?
		7. Intermittent claudication (pain in the legs that does not occur while standing or sitting. Severe when walking up stairs and goes away within 1-2 minutes at rest).
		8. Known heart murmur
		9. Unusual fatigue or shortness of breath with usual activities?

YES	NO	<b>TABLE 2: Please check "Yes" or "No" if you have the following:</b>
		1. Do you have Cardiovascular Disease?
		2. Do you have Pulmonary Disease (COPD, Interstitial lung disease, or cystic fibrosis) other than asthma?
		3. Do you have Metabolic Disease (diabetes mellitus, thyroid disorders, renal or liver disease)?

Do you chew tobacco? \_\_\_\_\_

Have you had any muscular/joint pain or discomfort during the past month? \_\_\_\_\_



Do you have any limitations or concerns that may affect your participation in an exercise and nutrition program? \_\_\_\_\_

YES	NO	<b>TABLE 3: CHD RISK FACTORS Please check Yes or No to the following questions:</b>
<b>+1</b>		<b>Family History For Heart Disease:</b> Father or other first-degree male relative (i.e. brother or son) had a heart attack, by-pass surgery or sudden death from a heart attack at age 55 or younger. Mother or other first-degree female relative had a heart attack, by-pass surgery or sudden death from a heart attack at age 65 or younger.

+1		<b>Smoking:</b> Current cigarette smoking and/or quit smoking within the past 6 months.
+1		<b>Physical Inactivity:</b> Do you seldom participate in a structured exercise program or recreational activities? Please list Cardiovascular Exercise Activities: Type _____ Duration _____ Times Per Week _____ <b>THE FOLLOWING TO BE COMPLETED BY FAI STAFF</b>
+1		<b>Hypertension:</b> BP _____ / _____. Blood pressure greater than 140/90 on at least 2 separate occasions. OR Taking antihypertensive medications.
+1		<b>High Cholesterol:</b> Cholesterol _____ . LDL _____ . HDL _____ . Total cholesterol greater than 200 mg/dl or HDL cholesterol less than 40 mg/dl if LDL not available. OR Use LDL >130 rather than total cholesterol of >200. OR Taking lipid-lowering medication.
+1		<b>Impaired Fasting Glucose:</b> Glucose _____. Fasting blood glucose greater than 100 mg/dl (confirmed by measurements on at least 2 separate occasions). OR fasting blood glucose greater than 125 mg/dl one time.
+1		<b>Obesity:</b> BMI 30 or above. BMI _____ . OR Waist measurement 40 inches or over for male & 35 inches or over for female. Waist _____ .
-1		<b>Negative:</b> HDL > 60 mg/dl. Subtract one risk factor from the sum above.

**Total:** \_\_\_\_\_.

**TREADMILL TEST CUT-OFF CRITERIA**

\_\_\_\_\_ Low Risk. Male less than 45 years old, female less than 55 years old with no symptoms (table 1) and no more than one risk factor (table 3).

Individual of any age with documented regular cardiovascular exercise activity (3 or more days per week for 30 or more minutes) with no more than one risk factor (table 3)

Sub-Maximal treadmill test at 85% of predicted heart rate maximum (can perform max test).

\_\_\_\_\_ Moderate Risk. Any male 45 years and older and any female 55 years and older with no documented regular cardiovascular exercise activity (3 or more days per week for 30 or more minutes). Individuals with two or more risk factors (table 3).

Sub-Maximal treadmill test walking protocol at 75% of predicted heart rate maximum.

**OR**

Single stage treadmill test.

\_\_\_\_\_ High Risk. Individuals with one or more symptoms (table 1), known cardiovascular, pulmonary or unstable metabolic disease (table 2), blood pressure over 160/100 or low potassium.

No treadmill test. Medical referral.



# NUTRITION INTAKE INVENTORY

Please record the number of servings in each of the food Categories you consume each day. Please do not change your diet while recording. If you can remember, record what you ate yesterday, record today and record one weekend day (if you have enough time before your wellness appointment).



<b>FOOD TYPE</b> <b>Listed Amounts = 1 Serving</b>	<b>DAY 1</b>	<b>DAY 2</b>	<b>DAY 3</b>	<b>TOTAL</b>
<b>WATER</b> Cups (8 oz) of Water				
<b>DAIRY: NON FAT</b> 1 Cup non fat Yogurt & Skim Milk Ounces of non fat Cheese				
<b>DAIRY: LOW FAT</b> 1 Cup Low Yogurt & Low Fat Milk Ounces of low fat Cheese, Cottage Cheese				
<b>DAIRY: HIGH FAT</b> 1 Cup Yogurt & Whole Fat Milk Ounces of Yellow Cheese & Cream Cheese				
<b>VEGETABLES</b> 1 Cup Raw Vegetables ½ Cup Whole & Cooked ¾ Cup Juice				
<b>FRUIT</b> Number of Medium Fruit Number of ½ Cups of Fruit ¾ Cups of Juice				
<b>GRAINS</b> Number of Slices of Bread Number of ½ Cups of Cereal, Beans, Legumes, Rice & Pasta				
<b>PROTEINS: LEAN</b> 2-3 Oz. Lean Meat, Poultry, Fish, Vegeburger 1 Cup Soy, Tofu 1 Oz. Nuts				
<b>PROTEINS: MEDIUM FAT</b> 2-3 Oz. Lean Ground Beef or Turkey, Chicken (no skin) Tuna 2 Tbs. Peanut Butter 1 Large Egg				

<b>PROTEINS: HIGH FAT</b> 2-3 Oz. Beef, Hamburger, Pork, Bacon, Sausage, Lamb, Hot Dogs and Most Deli Meats				
<b>FATS</b> 2 Tbs. Dressing, & Mayonnaise 1 Tbs. Butter, Oil or Margarine				
<b>SWEETS &amp; DESSERT- HIGH FAT</b> 1 sm. Candy Bar 2 sm. Cookies ½ cup Ice Cream 1 slice of Cake				
<b>SWEETS &amp; DESSERT- LOW FAT</b> 1 sm. Candy Bar 2 sm. Cookies ½ cup Ice Milk, low fat Ice Cream, Sherbet ½ Energy Bar				
<b>ALCOHOL</b> (1 oz hard liquor, 6 oz wine, 12 oz beer)				
<b>SUGAR DRINKS &amp; SODA</b> <b>(don't list diet drinks)</b> 12 oz Soda & Sugar Drinks 4 Tsp. Of Sugar or Jam				

## PHYSICAL ACTIVITY INVENTORY



Please record your structured physical activity including cardiovascular exercise, flexibility, strength training and calisthenics.

	MON	TUES	WED	THU	FRI	SAT	SUN
Activity Time Intensity							
Activity Time Intensity							
Activity Time Intensity							

# HEALTH HISTORY QUESTIONNAIRE

PLEASE COMPLETE THE FOLLOWING INFORMATION  
CONCERNING YOUR FAMILY HEALTH HISTORY

**MOM**

**DAD**

**Heart Disease:** Yes \_\_\_ Age \_\_\_  
**High Cholesterol:** Yes \_\_\_  
**Stroke:** Yes \_\_\_ Age \_\_\_  
**High BP:** Yes \_\_\_ Age \_\_\_  
**Diabetes (Type I, II):** Yes \_\_\_ Age \_\_\_  
**Cancer:** Yes \_\_\_  
 Type \_\_\_ Age \_\_\_  
**Osteoporosis:** Yes \_\_\_ Age \_\_\_  
**Obesity:** Yes \_\_\_  
**If Died.** Cause \_\_\_ Age \_\_\_

**Heart Disease:** Yes \_\_\_ Age \_\_\_  
**High Cholesterol:** Yes \_\_\_  
**Stroke:** Yes \_\_\_ Age \_\_\_  
**High BP:** Yes \_\_\_ Age \_\_\_  
**Diabetes (Type I, II):** Yes \_\_\_ Age \_\_\_  
**Cancer:** Yes \_\_\_  
 Type \_\_\_ Age \_\_\_  
**Osteoporosis:** Yes \_\_\_ Age \_\_\_  
**Obesity:** Yes \_\_\_  
**If Died.** Cause \_\_\_ Age \_\_\_

**Siblings**

**Siblings**

**List Who**

**List Who**

**Heart Disease:** Yes \_\_\_ Age \_\_\_  
**High Cholesterol:** Yes \_\_\_  
**Stroke:** Yes \_\_\_ Age \_\_\_  
**High BP:** Yes \_\_\_ Age \_\_\_  
**Diabetes (Type I, II):** Yes \_\_\_ Age \_\_\_  
**Cancer:** Yes \_\_\_  
 Type \_\_\_ Age \_\_\_  
**Osteoporosis:** Yes \_\_\_ Age \_\_\_  
**Obesity:** Yes \_\_\_  
**If Died.** Cause \_\_\_ Age \_\_\_

**Heart Disease:** Yes \_\_\_ Age \_\_\_  
**High Cholesterol:** Yes \_\_\_  
**Stroke:** Yes \_\_\_ Age \_\_\_  
**High BP:** Yes \_\_\_ Age \_\_\_  
**Diabetes (Type I, II):** Yes \_\_\_ Age \_\_\_  
**Cancer:** Yes \_\_\_  
 Type \_\_\_ Age \_\_\_  
**Osteoporosis:** Yes \_\_\_ Age \_\_\_  
**Obesity:** Yes \_\_\_  
**If Died.** Cause \_\_\_ Age \_\_\_

**GRANDMOTHER**

**GRANDFATHER**

**GRANDMOTHER**

**GRANDFATHER**

**Heart Disease:**  
Yes \_\_\_ Age \_\_\_  
**High Cholesterol:**  
Yes \_\_\_  
**Stroke:**  
Yes \_\_\_ Age \_\_\_  
**High BP:**  
Yes \_\_\_ Age \_\_\_  
**Diabetes (Type I, II):**  
Yes \_\_\_ Age \_\_\_  
**Cancer:**  
Yes \_\_\_ Age \_\_\_  
Type \_\_\_  
**Osteoporosis:**  
Yes \_\_\_ Age \_\_\_  
**Obesity:**  
Yes \_\_\_  
**If Died.** Age \_\_\_  
Cause

**Heart Disease:**  
Yes \_\_\_ Age \_\_\_  
**High Cholesterol:**  
Yes \_\_\_  
**Stroke:**  
Yes \_\_\_ Age \_\_\_  
**High BP:**  
Yes \_\_\_ Age \_\_\_  
**Diabetes (Type I, II):**  
Yes \_\_\_ Age \_\_\_  
**Cancer:**  
Yes \_\_\_ Age \_\_\_  
Type \_\_\_  
**Osteoporosis:**  
Yes \_\_\_ Age \_\_\_  
**Obesity:**  
Yes \_\_\_  
**If Died.** Age \_\_\_  
Cause

**Heart Disease:**  
Yes \_\_\_ Age \_\_\_  
**High Cholesterol:**  
Yes \_\_\_  
**Stroke:**  
Yes \_\_\_ Age \_\_\_  
**High BP:**  
Yes \_\_\_ Age \_\_\_  
**Diabetes (Type I, II):**  
Yes \_\_\_ Age \_\_\_  
**Cancer:**  
Yes \_\_\_ Age \_\_\_  
Type \_\_\_  
**Osteoporosis:**  
Yes \_\_\_ Age \_\_\_  
**Obesity:**  
Yes \_\_\_  
**If Died.** Age \_\_\_  
Cause

**Heart Disease:**  
Yes \_\_\_ Age \_\_\_  
**High Cholesterol:**  
Yes \_\_\_  
**Stroke:**  
Yes \_\_\_ Age \_\_\_  
**High BP:**  
Yes \_\_\_ Age \_\_\_  
**Diabetes (Type I, II):**  
Yes \_\_\_ Age \_\_\_  
**Cancer:**  
Yes \_\_\_ Age \_\_\_  
Type \_\_\_  
**Osteoporosis:**  
Yes \_\_\_ Age \_\_\_  
**Obesity:**  
Yes \_\_\_  
**If Died.** Age \_\_\_  
Cause