

DATE: _____



Health / Activity Information

California State University, Fullerton



Name: _____	
Address: _____	
City: _____	State: _____ Zip: _____
Home Phone #: () - _____	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Cell Phone #: () - _____	E-mail: _____
Date of Birth: / / _____	Height: _____ Weight: _____
Ethnicity: _____	Highest level of education: _____
Whom to contact in case of emergency: _____ Phone #: () - _____	
Relationship of emergency contact: _____	
Name of your Physician: _____	Phone #: () - _____

1. Have you ever been diagnosed as having any of the following conditions?

If Yes, Indicate Year of Diagnoses

Heart attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Transient ischemic attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Angina (chest pain)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Peripheral vascular disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Sensory Neuropathies (problems with sensation)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Respiratory disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Parkinson's disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Multiple sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Polio/Post Polio Syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>

Other neurological conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Rheumatoid arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Other arthritic conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Visual/depth perception problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Inner ear problems / Recurrent ear infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cerebellar problems (ataxia)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Other movement disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Chemical dependency (alcohol and/or drugs)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

**1B. The following questions relate to your risk for Cardiovascular Disease.
Do you have a personal history of any of the following?**

Cigarette smoking Yes No *Packs/day* _____, *yrs smoked* _____

Obesity or highly overweight Yes No _____

Physical inactivity Yes No _____

High blood pressure (over 140/90 mmHg) Yes No

Current Blood pressure _____

High cholesterol (over 200 mg/dl) Yes No *Cholesterol Level* _____

Diabetes or high blood sugar (over 110 mg/dl) Yes No

Blood glucose Level _____ *Year Diagnosed with Diabetes:* _____

Family history of heart attack/stroke, at young age Yes No

Indicate family member and age: _____

Continued on the next page

2. Have you ever been diagnosed as having any of the following conditions?

Cancer Yes No

If YES describe what kind: _____

Joint replacement Yes No Year: _____

If YES, how many times?

- Right Hip
- Left Hip
- Right Knee
- Left Knee

Cognitive disorder Yes No

If YES describe condition: _____

Uncorrected visual problems Yes No

If YES describe type: _____

Any other type of health problem? Yes No

If YES describe condition: _____

3. Do you currently suffer any of the following symptoms in your legs or feet?

Numbness Yes No

Tingling Yes No

Arthritis Yes No

Swelling Yes No

4. Do you currently have any medical conditions for which you see a physician regularly?

Yes No

If YES, please describe the conditions(s): _____

5. Do you require eyeglasses?

Yes No

If YES, what type of glasses do you wear?

- Bi-Focals
- Graded Lenses
- Magnification Only
- Tri-Focals

6. Do you have your eyesight checked at least once a year?

Yes No

7. Do you require hearing aids?

Yes No

If yes, which ear?

- Left Right Both

8. Do you use an assistive device for walking?

Yes No Sometimes

If YES or SOMETIMES, what type of assistive device do you use?

- Single-Point Cane
- 3-Point Cane
- Quad Cane
- Rolling Stand Walker
- 3-Wheel Walker w/Seat

Continued on the next page

9. List all medications that you currently take (including all “over-the-counter” and “alternative medicines”)

<i>Type of medication</i>	<i>For what condition</i>

10. Have you required emergency medical care or hospitalization in the past year? Yes No

If YES, please list when this occurred and briefly explain why.

11. Have you ever had any condition or suffered any injury that has affected your balance or ability to walk without assistance?

Yes No

If YES, please list when this occurred and briefly explain condition or injury.

12a. How many times have you fallen within the past 6 months? _____

If you have fallen in the past 6 months, please provide a detailed description of each incident as you remember it:

Fall #1:

(a) Date: _____

(b) Location (e.g., Bathroom, garden, grocery store): _____

(c) Reason for fall (e.g., uneven surface, going downstairs): _____

(d) Did you require medical treatment? Yes No

Fall #2:

(a) Date: _____

(b) Location (e.g., Bathroom, garden, grocery store): _____

(c) Reason for fall (e.g., uneven surface, going downstairs): _____

(d) Did you require medical treatment?

Yes No

12b. How many times have you fallen within the past year? _____

If you have fallen in the past year, please provide a detailed description of each incident as you remember it:

Fall #1- within the last year:

(a) Date: _____

(b) Location (e.g., Bathroom, garden, grocery store): _____

(c) Reason for fall (e.g., uneven surface, going downstairs): _____

(d) Did you require medical treatment? Yes No

Fall #2- within the last year:

(a) Date: _____

(b) Location (e.g., Bathroom, garden, grocery store): _____

(c) Reason for fall (e.g., uneven surface, going downstairs): _____

(d) Did you require medical treatment? Yes No

13. How concerned are you about falling?

1 - - - - - 2 - - - - - 3 - - - - - 4 - - - - - 5 - - - - - 6 - - - - - 7
Not at all a little moderately very extremely

14. As a result of this concern, have you stopped doing some of the things you used to do or liked to do?

Yes (1) No (2)

15. How would you describe your health (check)

Poor (1) Fair (2) Good (3) Very good (4) Excellent (5)

16. In the past 4 weeks, to what extent did health problems limit your everyday physical activities (such as walking and household chores)?

Not at all (1) Slightly (2) Moderately (3) Quite a bit (4) Extremely (5)

17. How much "bodily pain" have you generally had during the past 4 weeks? (While doing normal activities of daily living):

None (1) Very little (2) Moderate (3) Quite a bit (4) Severe (5)

18. In general, how much depression have you experienced within the past 4 weeks?

Not at all (1) Slightly (2) Moderately (3) Quite a bit (4) Extremely (5)

19. Choose the answer that best expresses how you felt over the course of the past week:

- a. Are you basically satisfied with your life? Yes No
- b. Do you often get bored? Yes No
- c. Do you often feel helpless? Yes No
- d. Do you stay at home rather than going out and doing new things? Yes No
- e. Do you feel pretty worthless the way you are now? Yes No

20. In general, how would you rate the quality of your life?

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 very low low moderate high very high

21. Please indicate your ability to do each of the following by placing an “x” in the most appropriate box).

	Can do	Can do with some difficulty	Can do with a lot of difficulty	Can not do without help	Can not do at all
a. Take care of own personal needs (e.g., dressing yourself)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Bathe yourself, using tub or shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Climb up and down a flight of stairs (e.g., second story)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Do light household activities (e.g., cooking, dusting, washing dishes, sweeping a walkway)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Do heavy household activities (e.g., scrubbing floors, vacuuming, raking leaves)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Do own shopping for groceries or clothes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Walk outside one or two blocks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Walk ½ mile (6-7 blocks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Walk 1 mile (12-14 blocks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Lift and carry 10 pounds (e.g., a full bag of groceries)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Lift and carry 25 pounds (e.g., medium-to-large suitcase)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Do strenuous activities (e.g., hiking, calisthenics, moving heavy objects, bicycling, aerobic dance activities, strenuous digging in garden)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. In general, do you currently require household or nursing assistance to carry out daily activities?

Yes No

If yes, please check the reasons(s)?

- Health problems
- Chronic pain
- Lack of strength or endurance
- Lack of flexibility or balance
- Other reasons: _____

23. In a typical week, how often do you leave your house? (to run errands, go to work, go to meetings, classes, church, social functions, etc.)

- less than once/week
- 1-2 times/week
- 3-4 times/week
- most every day

24. Do you currently participate in regular physical exercise (such as walking, sports, exercise classes, house work or yard work) that is strenuous enough to cause a noticeable increase in breathing, heart rate, or perspiration?

Yes No

If yes, how many days per week?

- One Two Three Four Five Six Seven

25. When you go for walks (if you do), which of the following best describes your walking pace:

- Strolling (easy pace, takes 30 min. or more to walk a mile)
- Average or normal (can walk a mile in 20-30 minutes)
- Fairly brisk (fast pace, can walk a mile in 15-20 minutes)
- Do not go for walks on a regular basis

26. Did you require assistance in completing this form?

None (or very little) Needed quite a bit of help

Reason: _____