Department of Wellness and Health Promotion  
A Division of Arkansas State University  
Promoting Health and Wellness within the ASU Community

Medical History and Risk Assessment Form

<table>
<thead>
<tr>
<th>Past History (have you ever had?)</th>
<th>Present Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Blood Pressure</td>
<td>Chest Pain/Discomfort</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>Arm, Back, Jaw Pain</td>
</tr>
<tr>
<td>Any Heart Attack</td>
<td>Shortness of Breath</td>
</tr>
<tr>
<td>Heart Palpitations</td>
<td>Asthma</td>
</tr>
<tr>
<td>Disease of arteries</td>
<td>Coughing of Blood</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Orthopedic Problems</td>
</tr>
<tr>
<td>Lung Disease</td>
<td>Swollen Ankles</td>
</tr>
<tr>
<td>Injuries to Back</td>
<td>Cough on Exertion</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>Arthritis/swollen, stiff, painful joints</td>
</tr>
<tr>
<td>Gout</td>
<td>Back Pain</td>
</tr>
<tr>
<td>Operations</td>
<td>Fainting or “light headedness”</td>
</tr>
</tbody>
</table>

Please list all operations

______________________________________________________________________________

______________________________________________________________________________
Family History (immediate family/grandparents)

Heart Attack  ○  Who? ________________  Age? ________
High Blood Pressure  ○  Who? ________________  Age? ________
High Cholesterol  ○  Who? ________________  Age? ________
Stroke  ○  Who? ________________  Age? ________
Diabetes  ○  Who? ________________  Age? ________
Congenital Heart Disease  ○  Who? ________________  Age? ________
Heart Operations  ○  Who? ________________  Age? ________
Early Death  ○  Who? ________________  Age? ________
Other Family Illness

If anyone in your family has had a heart attack please list relation and age when attack occurred.

Who ? ________________  Age? ________

Medications
None  ○
Anti-arrhythmias  ○  Quinine, procaine, amides
Diuretics and/or electrolytes  ○
Metabolic-insulin  ○
Thyroid  ○
Other (please list)

Risk Factors
Do you Smoke?  YES  NO
If Yes, how long? ____________________
How many/day? ____________________

Activity
Do you engage in physical activity?  YES  NO
What? ________________________________
How often? ________________________________

Indicate how active your lifestyle outside of work.
Sedentary  Active
Inactive  Very Active