DATE: ______________________________

Health / Activity Information

California State University, Fullerton

Name: ______________________________

Address: ______________________________

City ______________ *State:* ______________ *Zip:* ______________

Home Phone #: (   )   - ______ *Gender:* *Male* ☐ *Female* ☐

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 (A) **Have you ever been diagnosed as having any of the following conditions?**			**If Yes, Indicate Year of Diagnoses**
Heart attack	☐ Yes	☐ No	________
Transient ischemic attack	☐ Yes	☐ No	________
Angina (chest pain)	☐ Yes	☐ No	________
Stroke	☐ Yes	☐ No	________
Peripheral vascular disease	☐ Yes	☐ No	________
Sensory Neuropathies (problems with sensation)	☐ Yes	☐ No	________
Respiratory disease	☐ Yes	☐ No	________
Parkinson’s disease	☐ Yes	☐ No	________
Multiple sclerosis	☐ Yes	☐ No	________
Polio/Post Polio Syndrome	☐ Yes	☐ No	________

Continued on the next page

Continued from page 1			**If Yes, Indicate** ***Year of Diagnoses***
Other neurological conditions	☐ Yes	☐ No	______
Osteoporosis	☐ Yes	☐ No	______
Rheumatoid arthritis	☐ Yes	☐ No	______
Other arthritic conditions	☐ Yes	☐ No	______
Visual/depth perception problems	☐ Yes	☐ No	______
Inner ear problems / Recurrent ear infections	☐ Yes	☐ No	______
Cerebellar problems (ataxia)	☐ Yes	☐ No	______
Other movement disorders	☐ Yes	☐ No	______
Chemical dependency (alcohol and/or drugs)	☐ Yes	☐ No	______
Depression	☐ Yes	☐ No	______

1 (B) **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(s): _________

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

Continued on the next page

4. Do you currently have any medical conditions for which you see a physician regularly? ☐ Yes ☐ No

If YES describe condition: ____

____

____

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")

Type of medication	*For what condition*

Continued on the next page

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.__________

____

____

12 (A) **How many times have you fallen <u>within the past 6 months</u>?** __________

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

Continued on the next page

12 (B) **How many times have you fallen <u>within the past year</u>?** _______________

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?

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

Continued on the next page

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. Below are some statements about feelings and thoughts. Please place an "X" in the box that best describes your experience of each statement over the last 2 weeks.

Statements	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future.					
I've been feeling useful.					
I've been feeling relaxed.					
I've been feeling interested in other people.					
I've had energy to spare.					
I've been dealing with problems well.					
I've been thinking clearly.					
I've been feeling good about myself.					
I've been feeling close to other people.					
I've been feeling confident.					
I've been able to make up my own mind about things.					
I've been feeling loved.					
I've been interested in new things.					
I've been feeling cheerful.					

Continued on the next page

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

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

Continued on the next page

19. 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: ____________________________

____

20. 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
- ☐ 3-4 times/week
- ☐ 1-2 times/week
- ☐ most every day

21. 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

22. 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

23. Did you require assistance in completing this form?

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

Reason: ____

End of form

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