CARDIAC ONE RISK EVALUATION (CORE)
CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

Please print this form and fill out completely and return to Cory Fellhauer via email (cory.fellhauer@colostate.edu), fax (970-491-7677), or in person **at least 24 hours** prior to your appointment.

<table>
<tr><td colspan="4">Name:</td></tr>
<tr><td colspan="4">Address:</td></tr>
<tr><td colspan="2">City:</td><td>State:</td><td>Zip:</td></tr>
<tr><td>Home Phone:</td><td colspan="2">Work Phone:</td><td>Cell Phone:</td></tr>
<tr><td colspan="4">Email:</td></tr>
<tr><td colspan="2">Emergency contact
Name:</td><td colspan="2">Phone:</td></tr>
<tr><td colspan="4">Relation to you:</td></tr>
<tr><td colspan="4">Preferred method of contact:

☐Email (as provided above) or other: _____
☐Home Phone (as listed above)
☐Work Phone (as listed above)
☐Cell Phone</td></tr>
</table>

Date this form was completed: _____

Descriptive Information

1. Employer	
2a. Occupation	2b. # of years in the fire service
3. Date of Birth (month/day/year)	5. Age
4. Sex	6. Race/Ethnicity
7. Education: Please indicate the highest level of education completed. 7a. Please indicate degree earned (i.e. B.A., M.S., Ph.D.)	□ Grade School □ Junior High □ High School □ College _____ □ Graduate _____ □ Postgraduate _____
8. Marital Status	□ Married □ Widowed □ Divorced □ Single/never married □ Other (specify) _____

General Medical History

9. Has a doctor ever told you that you have any of the following health problems?

Condition	Yes	No	Comments (Provide details for any "yes" answer.)
a. Allergies			
b. Arthritis			
c. Angina Pectoris			
d. Asthma			
e. Cancer (except skin cancer)			
f. Diabetes			Type: _____ Age developed: _____
g. Gallbladder disease			
h. Heart disease			
i. High Blood Pressure			
j. High cholesterol			
k. Lung disease			
l. Migraine Headaches			
m. Osteoporosis			
n. Osteoarthritis			
o. Thyroid disorder			
p. Any other serious illness			

10. Any medical complaints presently?	□ Yes (Please explain in space below.) □ No
Explain medical complaints:	

11. Do you **currently** take any medications/pills? (including aspirin, vitamins, herbal supplements)? Yes No

Medication	Times per day	Dosage/ Units	Taken for how long?	Presently taking?	Reason for taking medication or supplement

12. Any hospitalization or surgery?
- □ No
- □ Yes Date: _____

Please explain.

13. Have you ever had an EKG (electrocardiogram)?
- □ No
- □ Yes 14a. Date: _____

13b. If yes, what were the findings?

13c. Have you ever had a previous stress test? ☐ No ☐ Yes Date: _____ 13d. If yes, what were the results and any subsequent testing.

Family History:

Relative	Age if alive (years)	Age of death (years)	Cause of death
14. Father			
15. Mother			

Do you have a family history of: (Blood relatives only: mother, father, sisters, brothers, sons, daughters. Provide age of occurrence if applicable).

Condition	Yes	No	Relationship	Age of Occurrence
16. High blood pressure				
17. Heart attack				
18. By-pass surgery				
18a. Sudden cardiac death				
18b. Stent or other revascularization				
19. Stroke				
20. Diabetes				
21. Overweight/Obesity				
22. High cholesterol				

23. Tobacco History: Do you currently use or have you previously used tobacco? (Includes cigarettes, snuff, chewing tobacco, pipes, cigars, and electronic cigarettes) Yes No

Type of tobacco	Quit? Year? (List when)	How Much?	Total years of use

23c. Does anyone living with you currently smoke cigarettes, cigars or pipes?	☐ Yes ☐ No

Alcohol Intake

24. Do you drink socially?	□ Yes □ No
24a. How many alcohol drinks to you usually have in a typical week? **One drink is:** 1 glass of wine (5 oz) 1 12 oz can of beer 1 mixed drink or shot of liquor	□ I do not drink □ Less than 1 drink □ 1-7 drinks □ 8-14 drinks □ 15 or more drinks

General Health

25. Would you say that your health in general is:	□ Excellent □ Very good □ Good □ Fair □ Poor
26. Compared to a year ago how would you rate your health in general now?	□ Much better than one year ago □ Somewhat better now than one year ago □ About the same as one year ago □ Somewhat worse than one year ago □ Much worse than one year ago

Cardio-Respiratory History	Yes	No
27. Have you been previously diagnosed with heart disease?		
28. Has a doctor ever told you that you have had a heart attack?		
29. Has a doctor ever told you that you have had a stroke?		
30. Do you have a heart murmur?		
31. Occasional chest pain or pressure? 31a. If yes, please describe it and when it occurs.		
32. Chest pain or pressure on exertion? 32a. If yes, please describe it and when it occurs.		
33. Do you ever experience a rapid heart rate or heart palpitations?		
34. Episodes of fainting?		
35. Daily coughing?		
36. Cough that produces sputum?		
37. Shortness of breath -- 37a. at rest		
37b. lying down		
37c. sleeping at night		

37d. after 2 flights of stairs		
38. Do you have asthma?		
38a. Have you ever been diagnosed with asthma like symptoms?		
38b. Have you ever been told you have childhood asthma?		
39. Do you have a history of bleeding disorders?		
40. Do you have a history of problems with blood clotting?		
41. Do you ever experience edema (fluid buildup)? 41a. If yes, please describe location and extent. 41b. Please describe any limitations to function:		
42. Do you have pain in your legs when you walk?		

Physical Activity

43. Please indicate how often you engage in cardio/aerobic activity and/or strength training.

Activity	Sessions per week	Time per session
Cardio (brisk walking, running, biking, swimming, rowing, etc.		
Strength training (weight lifting, Crossfit, etc.)		

Signature: _____

Date: _____