Occupational Medical Service
Montgomery County, MD

EXERCISE STRESS TEST QUESTIONAIRE

Name _____ Age _____

SSN_____

Personal Medical History

[ ] Yes [ ] No Do you have any health problems today that may prevent you from walking of jogging on a treadmill? If yes, explain:

Since your previous stress test here or within the past 3 years have you experienced:

[ ] Yes [ ] No High or borderline elevation of blood pressure?
[ ] Yes [ ] No Pain, tightness, or heaviness in heart, chest, or left arm?
[ ] Yes [ ] No Thumping, fluttering, or racing of heart while at rest?
[ ] Yes [ ] No Extra heart beats or skipped beats?
[ ] Yes [ ] No Swelling of both ankles at the same time?
[ ] Yes [ ] No Abnormal EKG, stress test or thallium scan?
[ ] Yes [ ] No Heart attack or angina?
[ ] Yes [ ] No Shortness of breath with activity long before anyone else?
[ ] Yes [ ] No Shortness of breath when sitting still or sleeping?
[ ] Yes [ ] No Elevated cholesterol and/or triglycerides?
[ ] Yes [ ] No A chronic or recurrent couth?
[ ] Yes [ ] No Any episode of coughing up blood?
[ ] Yes [ ] No Increased anxiety or reduced tolerance for stress?
[ ] Yes [ ] No Problem with unusual fatigue?
[ ] Yes [ ] No Pain or cramps in legs after walking short distances?
[ ] Yes [ ] No Recurrent or frequent swollen, stiff, or painful joints?
[ ] Yes [ ] No Back pain that requires medication?
[ ] Yes [ ] No Heart bypass surgery, angioplasty or blood vessel surgery?
[ ] Yes [ ] No Anemia?
[ ] Yes [ ] No Heart murmur?
[ ] Yes [ ] No Thyroid problem?
[ ] Yes [ ] No Phlebitis or blood clot?
[ ] Yes [ ] No Problem with balance?
[ ] Yes [ ] No Detached retina?
[ ] Yes [ ] No Abnormal chest x-ray?
[ ] Yes [ ] No Difficulty sleeping?
[ ] Yes [ ] No Diabetes?
[ ] Yes [ ] No Blood sugar too low?
[ ] Yes [ ] No Enlarged heart?
[ ] Yes [ ] No Injury to hip, knee, foot, or spine?
[ ] Yes [ ] No Surgery on hip, knee, foot or spine?
[ ] Yes [ ] No Stress related disorder?
[ ] Yes [ ] No Recurrent indigestion or heart burn?
[ ] Yes [ ] No Weight gain of 10 pounds or greater?
[ ] Yes [ ] No Pneumonia, asthma, or emphysema?
[ ] Yes [ ] No Stroke, paralysis, or numbness?
[ ] Yes [ ] No Dizziness, seizure, or faintness?

Please elaborate on any YES responses and include date of occurrence:

Medication / Diet History

List prescribed medications or over the counter medications taken in the past 24 hours:

List prescribed medications or over the counter medications taken in the past month:

List any drug allergies:

Amount of caffeine (coffee, tea, soft drinks) consumed in the past 12 hours? _____

Average daily caffeine consumption? _____

Family History (parents, grandparents, siblings)

[ ] Yes [ ] No Family member with heart attack or bypass surgery before age 55?
[ ] Yes [ ] No Family member with heart attack or bypass surgery after age 55?
[ ] Yes [ ] No Family member with stroke before age 55?
[ ] Yes [ ] No Family member with stroke after age 55?
[ ] Yes [ ] No Family member with high blood pressure?
[ ] Yes [ ] No Family member with diabetes?
[ ] Yes [ ] No Family member with elevated cholesterol/triglycerides?

Smoking History

[ ] Yes [ ] No Are you current cigarette smoker?

How many years have you smoked? _____

How many cigarettes per day? _____

[ ] Yes [ ] No If a female smoker, do you take oral contraceptives?
[ ] Yes [ ] No Are you a previous smoker who quit less than 2 years ago?

How many years did you smoked? _____

How many cigarettes per day? _____

Exercise History

[ ] Yes [ ] No Have you regularly exercised with the past 2 months?

If yes, anser the following:

Type of exercise	Days per week	Minutes per day

Employee Signature: _____ Date: _____