PARTICIPANT FORM

DATE ___________________________  BIRTHDATE ___________________________

GENDER ___________________________  ZIP CODE ___________________________

PERSONAL MEDICAL HISTORY (Y/N)

_____ Hypertension (high blood pressure)
_____ Hyperlipidemia (high cholesterol)
_____ Diabetes
_____ Heart Disease
_____ Coronary artery disease
_____ Heart Failure
_____ Tobacco use – current
_____ Tobacco use – past
_____ Family history of heart disease or stroke
     (first degree relative only)
_____ Stress

SOCIAL HISTORY (Y/N)

_____ Do you exercise regularly?
_____ If you answered “yes,” do you exercise more than 5 days each week?
_____ Do you exercise for longer than 30 minutes when you do exercise?

WEIGHT ___________________________  HEIGHT ___________________________