

## HEALTH HISTORY QUESTIONNAIRE (HHQ)

### Health History Questionnaire (HHQ)

Date: \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex  M  F

Physician's Name \_\_\_\_\_ Physician's Phone ( ) \_\_\_\_\_

**Contact Person in case of Emergency:**

Name \_\_\_\_\_ Phone (1) \_\_\_\_\_ Phone (2) \_\_\_\_\_

Are you taking any medications or drugs? If so, please list medication, dose, and reason.

\_\_\_\_\_

Does your physician know you are participating in this exercise program?

\_\_\_\_\_

Describe any physical activity you do somewhat regularly?

\_\_\_\_\_

YES NO

Do you now, or have you had in the past:

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1. History of heart problems, chest pain, or stroke
2. Increased blood pressure
3. Any chronic illness or condition
4. Difficulty with physical exercise
5. Experience dizziness, fainting, or blackouts
6. Advice from physician not to exercise
7. Recent surgery (last 12 months)
8. Pregnancy (now or within last 3 months)
9. History of breathing or lung problems (asthma)
10. Muscle, joint, or back disorder, or any previous illness still affecting you
11. Diabetes or thyroid condition
12. Cigarette smoking
13. Obesity (more than 20% over ideal body weight)
14. Increased blood cholesterol
15. History of heart problems in the immediate family
16. Hernia, or any other condition that may be aggravated by exercise

Please explain of any "yes" answers are marked.  
Comments:

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