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:
☐	☐	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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