

HEALTH HISTORY QUESTIONNAIRE (HHQ)

PLEASE PRINT, COMPLETE AND MAIL THIS FORM TO:



Tel: 0 5346377695

Email: merrettfitness@hotmail.co.uk

Today's date: _____ Date of birth: _____
Name: _____
Street Address: _____ City, : _____
Phone number: _____ E-mail: _____
Emergency Contact: _____ Emergency Phone: _____
Clinic/Physician: _____ Clinic/Physician Phone: _____

The Fitness program offers free educational sessions and workshops throughout the year.
Visit:

Please list all the days and time blocks you are available.

Monday _____ Tuesday _____
Wednesday _____ Thursday _____
Friday _____ Weekend _____

MARK ALL TRUE STATEMENTS REGARDING PERSONAL MEDICAL HISTORY

Cardiovascular Risk Factors

- ☐ I am a man older than 45 years of age
- ☐ I am a woman older than 55 years of age, have had a hysterectomy, or am menopausal
- ☐ I smoke, or quit smoking within the past 6 months
- ☐ I take blood pressure medication
- ☐ I do not know my blood pressure
- ☐ I have a close blood relative who had a heart attack or heart surgery before age 55 (father or brother) or age 65 (mother or sister)
- ☐ I am physically inactive - less than 30 minutes of physical activity at least 3 days per week
- ☐ I am more than 20 pounds overweight

History

- ☐ I have had a heart attack
- ☐ I have had heart surgery
- ☐ I have coronary heart disease
- ☐ I have a pacemaker / implantable cardiac
- ☐ I have had a defibrillator / rhythm disturbance
- ☐ I have heart valve disease
- ☐ I have had heart failure
- ☐ I had a heart transplant
- ☐ I have congenital heart disease

Symptoms

- ☐ I experience chest discomfort with exertion
- ☐ I experience unreasonable breathlessness
- ☐ I experience dizziness, fainting or blackouts
- ☐ I take heart medications

Other Health Issues

- ☐ I have diabetes
- ☐ I have asthma or other lung disease
- ☐ I have burning or cramping sensations in my lower legs when walking short distances
- ☐ I have musculoskeletal problems that limit my physical activity
- ☐ I have concerns about the safety of exercise
- ☐ I take a, or more than one, prescription medication
- ☐ I am pregnant
- ☐ None of the above

If you marked two or more of the statements in the “cardiovascular risk factors” section, you will need to consult with a physician or qualified health care provider prior to engaging in exercise.

FAMILY MEDICAL HISTORY

Please indicate all that apply to your mother, father or siblings:

- ☐ Cardiovascular disease
- ☐ Stroke
- ☐ Pulmonary disease
- ☐ Sudden death
- ☐ Metabolic disease

PERSONAL MEDICATIONS

Please list specific prescription medications that you are currently taking. Include vitamins, supplements, herbs, over-the-counter remedies, etc.

DIETARY HABITS

Please indicate all that apply:

- ☐ frequently consume red or high-fat meats
- ☐ eat 5 servings of fruits/vegetable a day
- ☐ pursue low-fat diet
- ☐ almost always eat a healthy breakfast
- ☐ include many high-fiber foods in daily diet
- ☐ rarely eat high-sugar or -fat desserts
- ☐ consume at least 64 oz. fluid per day
- ☐ consciously monitor portion sizes
- ☐ eat at restaurants/fast food 3+ times/week
- ☐ drink one or more cans of soda a day

What is your approximate water intake per day pints/liter?

Circle how closely you monitor your dietary habits:

1 2 3 4 5 6 7 8 9 10 - (not at all moderately extreme)

“I eat what I want”

“I am conscious of what I eat”

“I closely monitor everything”

LIFESTYLE

Are you a smoker? _____

How many a day? _____

How long have you smoked? _____

If you smoked in the past, how long has it been since you quit? _____

Do you consume alcoholic beverages? _____

How many units per week? _____

½ pint of beer = 1 unit

1 glass of wine = 1 unit

1 pub measure of spirits, e.g. gin, vodka = 1 unit

1 can of beer = 1 ½ units

1 bottle of strong lager = 2 ½ units

1 bottle of wine = 7 units

1 liter bottle of wine = 10 units

1 bottle of fortified wine, e.g. port, sherry = 14 units

1 bottle of spirits = 30 units

Please indicate your daily stress level

___ Low

___ Moderate

___ High (I enjoy the challenge)

___ High (sometimes difficult to handle)

___ High (often times too difficult to handle)

CURRENT PHYSICAL ACTIVITY

On average, how many times do you exercise per week? _____

On average, how long do you exercise per session? _____

What does a typical exercise session include?

E.g. walking, running, swimming, group fitness.

Indicate your current physical activity during an average work day:

___ Sitting most of the time, with very little movement

___ Walking around, moving some of the time, but mostly sitting

___ Fairly active, standing or moving most of the time

___ Very active, strenuous work for long periods of time with little rest

PERSONAL HEALTH AND FITNESS GOALS

Please list your personal health and fitness goals in order of priority:

1)

2)

3)

Please describe your current physical activity, or a typical exercise session in detail below.

What types of activities, equipment or specific exercises do you prefer?

What barriers to success do you anticipate?

How much time during the week are you able to dedicate to your exercise program?

Please indicate any other medical conditions or activity restriction that you may have. This should include broken bones, recent or abnormal sprains/strains, surgeries, pain when performing certain activities, etc. It is important that this information be as accurate and detailed as possible.

Circle your current motivation level: low medium high

Circle your current confidence level: low medium high

Circle your readiness for change: low medium high

Thank you for completing the HHQ. I will contact you within 3-5 business days of receiving your HHQ. I look forward to working with you