Health History Questionnaire

Please answer the following questions to the best of your ability. For the following questions, unless otherwise indicated, circle the single best choice for each question. As is customary, all of your responses are completely confidential and may only be used in group summaries and/or reports. All information collected is subject to the Privacy Act of 1974. If you have any physical handicaps or limitations that would require special assistance with this questionnaire, please let PROMATx

Name: _____ **Ht.** _____ **Wt.**_____

Gender: M / F Age: ____ **Birthdate:** _____ **Occupation:**_____

Address: _____

City:_____ **State:**_____ **Zip:** _____

Home Phone:_____ **Work Phone:** _____

Cell Phone/Pager: _____ **Email**_____

Personal Physician: _____ **Phone:** _____

1. Have you ever had a definite or suspected heart attack or stroke?..... Yes No
2. Have you ever had coronary bypass surgery or any other type of heart surgery?..... Yes No
3. Do you have any other cardiovascular or pulmonary (lung) disease
   (**other than asthma, allergies, or mitral valve prolapse**)?..... Yes No
4. Have you ever had a history of diabetes, thyroid, kidney, or liver disease?
   (please circle one)..... Yes No
5. Have you ever been told by a health professional that you have an
   Abnormal resting or exercise (treadmill) electrocardiogram (EKG)..... Yes No
6. If you answered YES to any of Questions 1 through 5, please describe.

   _____

   _____

7. Do you have any of the following:
   a. Pain or discomfort in the chest or surrounding areas that occurs
      When you engage in physical activity?..... Yes No
   b. Shortness of breath..... Yes No
   c. Unexplained dizziness or fainting..... Yes No
   d. Difficulty breathing at night except in upright positions..... Yes No
   e. Swelling of the ankles (recurrent and unrelated to injury)..... Yes No
   f. Heart Palpitations (irregularity or racing of the heart on more than one occasion)..... Yes No
   g. Pain in legs that causes you to stop walking (claudication)..... Yes No
   - Known heart murmur..... Yes No
     - Have you ever discussed this with your personal physician?..... Yes No
8. Are you pregnant or is it likely that you are pregnant at this time?..... Yes No
   If yes, what is your expected due date?_____
9. Have you had surgery or been diagnosed with any disease in the past 3 months?.... Yes No
   If yes, please list date _____ and surgery/disease_____
10. Have you had high cholesterol or abnormal lipids within the past 12 months or are taking medication to control your lipids?..... Yes No
11. Do you currently smoke cigarettes or have quit within the past 6 months? ..... Yes No

12. Have your father or brother(s) had heart disease prior to age 55 OR mother or sister(s) had heart disease prior to age 65?
..... Yes No

13. Within the past 12 months, has a health professional told you that you have high blood pressure (systolic ≥ 140 OR diastolic ≥ 90)?
..... Yes No

14. Currently, do you have high blood pressure or within the past 12 months have you taken any medicines to control your blood pressure? ..... Yes No

15. Have you ever been told by a health professional that you have high blood sugar or diabetes?
..... Yes No

16. Are you under any Treatment for Blood Clots?..... Yes No

17. Do you have any problems with bones, joints, or muscles that may be aggravated with Exercise?..... Yes No

18. Do you have any back/neck problems?..... Yes No

19. Have you been told by a health professional that you should not exercise" ..... Yes No

20. Are you currently being treated for any other medical conditions by a physician?..... Yes No

21. Are there any other conditions (mitral valve prolapse, epilepsy, history of rheumatic fever, Asthma, cancer, anemia, hepitits, etc.) that may hinder tour ability to exercise..... Yes No

22. During the past six months, have you experienced any unexplained weight loss or gain (greater than ten pounds for no known reason.)..... Yes No

23. If you answered YES to any of the questions 18-24, please describe:_____

_____

_____

_____

24. Please list below all prescription and over-the-counter medications you are currently taking:

Medicine:	Reason for taking:	Dosage:	Amount/Frequency:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

25. Are there any medicines that you physicians has prescribed to you in the past 12 months

Which you are not currently taking?..... Yes No

If so, please list:_____

_____

I have answered the HHQ questions accurately and completely. I understand that my medical history is a very important factor in the development of my fitness/wellness program. I understand that certain medical or physical conditions which are known to me. If any of the above conditions change, I will immediately inform PROMATx of those changes. I , knowingly and willingly, assume all risks of injury resulting from my failure to disclose accurate, complete, and updated information in accordance with the attached questionnaire. I also understand that in order to properly risk stratify my HHQ, my trainer should have a minimum of a national certification as a personal trainer. PROMATx also verbally explained this agreement to me to my understanding..

Clients Signature:_____ Date:_____

PROMATx Signature:_____ Date:_____