FIU Student Affairs
Wellness and Recreation Center – MMC

HEALTH HISTORY QUESTIONNAIRE (HHQ)

Contact Information

Today's Date _____ Employee ID # _____ Date of Birth _____

Name _____ Phone # _____ Email Address _____

Street address / City / State / Zip Code _____ Sex (circle) M / F

Please identify your membership status with FIU Recreation Services (circle): Student Gold Blue

Emergency and Physician Contacts

Primary Emergency Contact _____ Emergency Contact Phone # _____

Clinic/Physician _____ Clinic/Physician Phone # _____

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:

_____ I emphasize lean meats and avoid red or high-fat
_____ I eat 5 servings of vegetables per day
_____ I pursue a low-fat diet
_____ I use an online nutrition tracking tool daily
_____ I almost always eat a full, healthy breakfast
_____ I include many high-fiber foods in my diet
_____ I rarely eat high-sugar or high-fat desserts
_____ I would like assistance with weight loss

On a scale of 1-10, how closely do you monitor your dietary habits? (*Note: "1" indicates that you do not monitor your dietary habits, while "10" indicates that you closely monitor everything*). _____

Regarding your nutrition, what barriers prevent you from achieving your goals? *(i.e. overeating, unhealthy snacks/foods, not enough time to cook, etc.)*

_____

_____

Lifestyle

Are you a current smoker (circle)? Y / N

If you are a current smoker, how much do you smoke per day? _____

Are you a previous smoker (circle)? Y / N

If you are a previous smoker, when did you quit? _____

Please rate your daily stress level:

_____ Low
_____ Moderate
_____ High: I enjoy the challenge
_____ High: Sometimes difficult to handle
_____ High: Often 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? _____

Do you attend Group Fitness classes regularly (3-5 classes per week?) Y / N

If you circled yes, in which Group Fitness classes do you _____

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

What are your current fitness goals? (check any that apply)

____ Build/gain muscle
____ Increase body fat percentage
____ Decrease body fat percentage
____ Lose weight
____ Tighten/tone muscles
____ Increase endurance/stamina
____ Increase power
____ Increase agility & speed
____ Other: (please describe)

Why do you want to attain these goals?

What do you think prevents you from achieving these goals?

Which types of activities, equipment, or specific exercises do you prefer? And, which do you absolutely avoid?

Do you currently use a heart rate monitor during exercise sessions? (Circle) Y / N

Please indicate below any other medical conditions that affect or restrict your physical activity. This should include broken bones, recent sprains/strains, surgeries, pain when performing certain activities, etc. It is important that this information is as accurate and detailed as possible.

Family Medical History

Please indicate below if your mother, father or blood-related siblings have had any of the following conditions:

_____ Paternal heart attack, surgery or sudden death prior to age 55
_____ Maternal heart attack, surgery or sudden death prior to age 65
_____ Stroke prior to age 50
_____ Hypertension
_____ Leukemia or cancer prior to age 60
_____ High cholesterol (blood cholesterol level is > 200 mg/ dL)
_____ Diagnosed Diabetes
_____ Obesity
_____ Asthma
_____ Osteoporosis

Medical History

Cardiovascular Risk Factors**

_____ I am a man older than 45 years of age
_____ My blood pressure is > 140 / 90 mmHg
_____ I take blood pressure medication
_____ My blood cholesterol level is > 200 mg/ dL (or I do not know my cholesterol)
_____ My blood glucose is >100mg/dL & <125mg/dL IGT or >140 OGTT (or I am a diagnosed Diabetic)
_____ I smoke, or quit smoking within the past 6 months
_____ I exercise less than 30 minutes at least 3 days a week
_____ I am more than 20 pounds overweight
_____ I am a woman older than 55 years of age, have had a hysterectomy, or am menopausal

Known Disease History

_____ I have had heart attack, failure or surgery
_____ I have had cardiac catheterization
_____ I have had coronary angioplasty (PTCA)
_____ I have a pacemaker
_____ I have had a heart transplant
_____ I have COPD
_____ I have asthma
_____ I have cystic fibrosis
_____ I have Diabetes (Type I or II)
_____ I have renal (kidney) disease

Signs & Symptoms

_____ I experience chest, neck, jaw, or arm discomfort/pain with physical exertion
_____ I experience unreasonable shortness of breath
_____ I experience ankle edema (swelling of the ankles)
_____ I experience dizziness, fainting or blackouts
_____ I have a known heart murmur
_____ I experience heart palpitations

Other Health Issues

_____ I have hypothyroidism or hyperthyroidism
_____ I am pregnant
_____ I take one or more prescription medications
Please explain _____
_____
_____ I have a current musculoskeletal issue that affects my physical activity (shoulder or knee injury, etc.)
Please explain _____
_____

For Trainer Use:

Known Disease or Signs & Symptoms of Disease? Y/N

Yes=High Risk Physician's Clearance Needed Before Assessment and/or Exercise

No=Calculate Total Cardiovascular Risk Factors** _____

Risk: Low (0-1) _____ Moderate (2+) _____