UCCS Campus Recreation
UNIVERSITY OF COLORADO COLORADO SPRINGS

HEALTH HISTORY QUESTIONNAIRE (HHQ)

PLEASE COMPLETE AND SEND THIS FORM TO:

Coordinator of Fitness
fitness@uccs.edu
UCCS Recreation Center
1420 Austin Bluffs Parkway
Colorado Springs, CO 80918

Today's date: _____ Date of birth: _____

Name: _____ Student/Staff ID#: _____

Height: _____ Weight: _____

Street Address: _____ City, State, Zip: _____

Phone number: _____ Email: _____

Emergency Contact: _____ Emergency Phone: _____

Clinic/Physician: _____ Clinic/Physician Phone: _____

Program/Service Desired (check):

___ Fitness assessment only
___ Personal training
___ Partner training. Partner name: _____ (Each partner must submit an HHQ.)

For more information regarding the above programs/services and pricing, please visit:
www.uccs.edu/fitness

Please list all the days and time blocks you are available to meet with a personal trainer. Campus Recreation facilities open as early as 6am on weekdays, and personal trainers can meet with clients until as late as 10pm.

Monday _____ Friday _____

Tuesday _____ Saturday _____

Wednesday _____ Sunday _____

Thursday _____

Do you have any preferences regarding your personal trainer? _____

_____

Please check any statements that apply to your personal medical history.

Symptoms

___ I experience chest discomfort with exertion
___ I experience unreasonable breathlessness
___ I experience dizziness, fainting or blackouts
___ I experience ankle swelling
___ I experience unpleasant awareness of a forceful, rapid or irregular heart rate
___ I experience burning or cramping sensations in my lower legs when walking short distances
___ None of the above

Current Activity

___ I spend most of my work day sitting
___ I have engaged in exercise (planned, structured physical activity) for at least 30 minutes a day at moderate intensity or higher on at least 3 days per week for at least the past 3 months

Please describe your current exercise habits. _____

_____

Medical Conditions

___ I have had a heart attack
___ I have had heart surgery, cardiac catheterization or coronary angioplasty
___ I have a pacemaker / implantable cardiac defibrillator / rhythm disturbance
___ I have heart valve disease
___ I have had heart failure or a heart transplant
___ I have congenital heart disease
___ I have diabetes
___ I have renal disease
___ None of the above

If you checked any of the statements in the "symptoms" section, you will need to obtain clearance from your physician or qualified health care provider prior to engaging in exercise.

Risk Factors

___ I smoke, or quit smoking within the past 6 months
___ My blood pressure is > 140 / 90 mmHg
___ My blood cholesterol level is > 200 mg/dL
___ I lose my balance because of dizziness
___ I have asthma or other lung disease
___ I have a bone, joint or muscular problem that could be made worse by physical activity
___ I struggle with or have been medically diagnosed with an eating or exercise disorder
___ I am pregnant
___ None of the above

Please list all medications you are currently taking and why. Include prescriptions, vitamins, supplements, over-the-counter remedies, etc.

_____

_____

Nutrition

Please indicate all that apply:

___ I try to avoid red or high-fat meats
___ I need assistance with my weight loss
___ I eat 5 servings of fruits/vegetables per day
___ I almost always eat a healthy breakfast
___ I drink one or more servings of soda per day
___ I include many high-fiber foods in my diet
___ I eat at restaurants/fast food often
___ I use an online nutrition tracking tool
___ I have a dietary allergy

Health and Fitness Goals

What do you currently rely on as an indicator of your health and fitness—body fat percentage, strength, endurance, body weight, or something else?

_____

_____

Please list your personal health and fitness goals. _____

_____

_____

Regarding your health and fitness, what challenges exist with regard to your goals?

_____

_____

Why are you pursuing personal training? _____

_____

What types of activities or exercises do you enjoy? _____

_____

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

_____

_____

Please leave any other comments or questions you would like to be addressed or want your personal trainer to know:

_____

_____

Thank you for completing the HHQ. A personal trainer will contact you within 7 business days of receiving your HHQ and registration. We look forward to working with you!