aegis therapies® rehab and wellness services

EnerG by aegis

HEALTH HISTORY QUESTIONNAIRE

NAME:	EMAIL:	
MAILING ADDRESS:		
TELEPHONE NUMBER/EXT.:	D.O.B.:	AGE:

UNDERSTANDING THE HEALTH HISTORY QUESTIONNAIRE

All of your responses shall be kept strictly confidential and will become part of your membership record. Any group summaries or activity reports that Aegis Therapies may create shall have individual identifiers removed. The Health History Questionnaire is not a substitute for a thorough physical examination, assessment and diagnosis by your physician. It has been designed to identify adults for whom physical activity might be inappropriate at this time. Please answer each question accordingly.

GENERAL HISTORY		
Are you a male over 45 or female over 50 who is not accustomed to regular exercise?	☐ YES	☐ NO
Have you undergone a complete medical examination in the past 5 years?	☐ YES	☐ NO
Are you on a special diet? If yes, what type? _____	☐ YES	☐ NO
Have you gained or lost more than 10 pounds in the last 6 months?	☐ YES	☐ NO
Do you currently have an illness or infection? If yes, please specify: _____	☐ YES	☐ NO
Do you have allergies? Please specify: _____	☐ YES	☐ NO
Has your physician ever told you that:		
• Your cholesterol was too high?	☐ YES	☐ NO
• Your triglycerides were too high?	☐ YES	☐ NO
• Your uric acid was too high?	☐ YES	☐ NO
Do you have history of high blood pressure?	☐ YES	☐ NO
Do you have any of the following conditions?		
• Diabetes	☐ YES	☐ NO
• Liver disorder	☐ YES	☐ NO
• Renal disorder	☐ YES	☐ NO
• Thyroid disorder	☐ YES	☐ NO

SMOKING HISTORY		
Do you presently smoke?	☐ YES	☐ NO
If you are an ex-smoker, when did you quit? _____		
Number of years smoking? _____		
Number of cigarettes, cigars and pipe bowls smoked per day: _____		

CARDIOVASCULAR/CIRCULATORY HISTORY		
Has any immediate family member (parents or siblings) had a heart attack, heart condition/ ailment, heart surgery, stroke, etc.? If yes, who and at what age did it occur? _____ If sudden death, at what age did it occur? ☐ UNDER 50 ☐ OVER 65	☐ YES	☐ NO
Have you ever been told you have any of the following:		
• Heart attack or heart failure	☐ YES	☐ NO
• Stroke	☐ YES	☐ NO
• Heart bypass, valvular surgery or angioplasty	☐ YES	☐ NO
• Heart enlargement or conduction defect	☐ YES	☐ NO
• Heart murmur (current)	☐ YES	☐ NO
• Abnormal resting or exercise electrocardiogram	☐ YES	☐ NO
Please specify abnormality: _____		
• Other heart condition: _____		
Do you have a history of any of the following:		
• Pain or tightness in the chest, neck, shoulder or arms at rest or during exercise?	☐ YES	☐ NO
• Rapid beating of your heart not associated with exercise?	☐ YES	☐ NO
• Palpitations or skipped beats at rest or during exercise?	☐ YES	☐ NO
• Severe dizziness or chronic light-headedness?	☐ YES	☐ NO
• Badly swollen feet or ankles?	☐ YES	☐ NO

PULMONARY HISTORY		
Do you suffer from pulmonary disease that may become aggravated by exercise or becomes worse with exercise?	☐ YES	☐ NO
Do you experience extreme breathlessness after mild exercise?	☐ YES	☐ NO
Have you ever experienced any of the following?		
• Asthmas? When: _____	☐ YES	☐ NO
• Bronchitis? When: _____	☐ YES	☐ NO
• Emphysema? When: _____	☐ YES	☐ NO
• Pneumonia? When: _____	☐ YES	☐ NO
• Other? Specify: _____	☐ YES	☐ NO

MUSCULOSKELETAL HISTORY		
Do you have a bone or joint problem that becomes aggravated by exercise or becomes worse with exercise? Please specify: _____	☐ YES	☐ NO
Are you currently receiving physical therapy treatment? Please specify condition: _____	☐ YES	☐ NO

Do you have a history of the following:		
• Lower back pain	☐ YES	☐ NO
• Spinal disc problems	☐ YES	☐ NO
• Cartilage or tendon tear	☐ YES	☐ NO
• Osteopenia/osteoporosis	☐ YES	☐ NO
• Arthritis/bursitis	☐ YES	☐ NO
• Ligament sprain	☐ YES	☐ NO

MEDICATION HISTORY

Are you currently taking any medication/supplements?	☐ YES	☐ NO

MEDICATION	DOSE	CONDITION

OTHER MEDICAL HISTORY/SURGERIES

Please discuss any significant medical problems:

Primary Physician Information

Name: _____

Office Number: _____

Address: _____

_____

I understand the nature and purpose of the Health History Questionnaire and I am aware that any physical activity involves risks. Accordingly, I release, discharge, absolve and hold harmless Aegis Therapies agents and employees, instructors and volunteers from any and all liability arising out of any accident, injury or loss sustained by me as a result of activities at or present in the Aegis Therapies facilities.

I declare to the best of my knowledge my answers are true, correct and complete.

_____ _____

Signature Date

HHQ reviewed by:

_____ _____

Signature (Authorized Aegis Therapies) Date