

MEDICAL QUESTIONNAIRE

The following medical questionnaire is a sample product commonly used by health professionals. Please complete the following information as accurately and completely as possible so that your doctor and health professional can assess your suitability to undergo a fitness assessment, exercise test, or begin an exercise or health based program.

Name:

Gender:

Date of Birth:

Address:

.....

Phone:

E-mail:

Cardiovascular, Pulmonary or Metabolic Disease. Have you ever been diagnosed with, or do you think you may have any of the following diseases / disorders / conditions, or have you had any of the following procedures?

- Yes No (1) Myocardial infarction (heart attack)?
- Yes No (2) Stroke or ischemic attack (mini stroke)?
- Yes No (3) Heart bypass surgery or other heart surgery?
- Yes No (4) Coronary catheterization and/or angioplasty?
- Yes No (5) Abnormal ECG (tachycardias, heart blocks etc)?
- Yes No (6) Other cardiovascular disease/disorder (aneurysm)?
- Yes No (7) Chronic obstructive pulmonary disease (COPD etc)?
- Yes No (8) Diabetes (insulin dependent, non insulin dependant etc)?
- Yes No (9) Hyperlipidemia (high LDL, low HDL, etc)?

Comment:

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Signs or symptoms suggestive of Cardiopulmonary Disease. Have you experienced any of the following?

- Yes No (10) Pain / discomfort in you chest, jaw or arms?
- Yes No (11) Shortness of breath at rest, or mild exertion?
- Yes No (12) Dizziness or fainting spells?
- Yes No (13) Swelling of your ankles?
- Yes No (14) ‘Skipping’ heart beats or a ‘racing’ heart beat?
- Yes No (15) Occasional leg pain, especially while walking?
- Yes No (16) Heart murmur?
- Yes No (17) Fatigue or shortness of breath with usual activities?

Comments:
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Risk factors of Cardiovascular Disease. Do you have a personal history of any of the following?

- Yes No (18) Cigarette smoking?
- Yes No (19) Obesity or being highly overweight?
- Yes No (20) A lack of physical activity?
- Yes No (21) High blood pressure (over 140/90 mmHg)?
- Yes No (22) High Cholesterol (over 200 mg/dl)?
- Yes No (23) Diabetes or high blood sugar (over 110 mg/dl)?
- Yes No (24) Family history of heart attack or stroke at a young age?

Comment:.....
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General Health. Please answer the following questions.

- Yes No (25) Have you had Glandular Fever?
- Yes No (26) Do you suffer from Epilepsy?
- Yes No (27) Do you have arthritis?
- Yes No (28) Do you have asthma?
- Yes No (29) Do you suffer from cramps?
- Yes No (30) Have you suffered any major pain or injury to the back, neck, shoulders, knees, ankles or other body part?
- Yes No (31) Have you had any significant surgery or operation?
- Yes No (32) Do you suffer from, or think you may be suffering from, any illness or injury not listed on this form?
- Yes No (33) Do you have any issues that you would like to discuss with your doctor prior to undergoing a fitness assessment, exercise test or physical activity program

Comments:.....
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Physical Activity Readiness Questionnaire. Please answer the following questions.

- Yes No (34) (For females) Are you pregnant?
- Yes No (35) Do you have any condition or issue that may be worsened by physical activity?
- Yes No (36) Do you feel pain in your chest when you do physical activity?

- () Yes () No (37) In the past month, have you had a chest pain when you were not physically active?
- () Yes () No (38) Do you lose your balance because of dizziness, or do you ever lose consciousness?
- () Yes () No (39) Do you have a bone or joint problem that could be made worse by a change in your physical activity?
- () Yes () No (40) Is your doctor currently prescribing drugs for your blood pressure or heart condition?
- () Yes () No (41) Has your doctor ever given you recommendations regarding physical activity? (if so explain what they were and why).
- () Yes () No (42) Do you know of any other reason why you should not do any physical activity?

Comment:.....

What is your current level of physical activity and exercise?
 How frequent:.....
 How intense:.....
 Session lengths:.....
 Types of activity:.....

Drugs / Medications. Please list any prescribed, or over the counter drugs / medications you are currently taking.

Drug / Medication.	Purpose / Reason for taking.
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Doctor / Health plan information. If you are on a health plan please provide the following details.

Name:
 Address:
 Phone / fax:

Emergency contact details.

Name:
 Phone:

This assessment of your health history is used to provide detailed information regarding your health and fitness. This information should be shown to your doctor to assess your level of risk for the activities you are planning to take part in.

This document should also be provided to your health professional to allow them to assess your suitability for the programs they are conducting with you. If you answered yes to any of these questions your health professional may require you to provide Medical Clearance, along with possible recommendations regarding any health issues, before you can participate in any activity or program. Trainers may also request the completion of an assessment consent form which they will provide.

DECLARATION.

If you have ticked ‘yes’ to any question listed in the questionnaire, please ask for written clearance from your doctor ‘OR’ If you have already cleared these conditions with your doctor please sign directly below.

Signed:
Name (printed).

Upon completion of this form, ‘**I declare and understand the following**’:

Initial

- I have completed this health history to the best of my recollection and have not knowingly withheld any information concerning my health.
- I understand that this information will be used to assess my ‘risk category’ for my participation in a fitness assessment, exercise test, physical activity or other health based program.
- I understand that I may be excluded from any physical activity based on my exercise risk, or that my participation may in some way be restricted or altered.
- I accept that most health and fitness providers such as Personal Trainers etc, are not qualified to offer medical advice and I should act in accordance with the advice of my doctor.

Signed:
Name (printed):
Date:

Note: This questionnaire is based on standards used in the Australian Fitness Industry, and on a ‘risk’ assessment as originally established by the American College of Sports Medicine. Ask your doctor or health professional if this form is suitable for their needs (located at www.fitaussie.com or www.fitnations.com).