

## PRE-EXERCISE QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential

Name (Last, First, M.I.):

DOB:

M  F

Address:

Phone:

Mobile:

Email:

Emergency Contact:

### MEDICAL HISTORY

Has anyone in your family under 60 suffered from Heart Disease, Stroke, Raised Cholesterol or Sudden Death?  No  Yes

Are you male over 35 or female over 45 and not used to regular exercise?  No  Yes

Have you been hospitalised recently?  No  Yes

Date of last medical exam:

Are you currently taking prescription medication?  No  Yes

Have you given birth in the last 6 weeks?  No  Yes      Are you or could you be pregnant?  No  Yes

### Have you ever had or do you have any of the following:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Gout                               | <input type="checkbox"/> Stomach/Duodenal Ulcer | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> High Blood Pressure $\geq(130/90)$ | <input type="checkbox"/> Liver/Kidney Condition | <input type="checkbox"/> Hernia          |
| <input type="checkbox"/> Stroke                             | <input type="checkbox"/> Any Heart Condition    | <input type="checkbox"/> Glandular Fever |
| <input type="checkbox"/> Palpitations / pain in chest       | <input type="checkbox"/> Diabetes Type I        | <input type="checkbox"/> Heart murmur    |
| <input type="checkbox"/> Dizzy /Fainting                    | <input type="checkbox"/> Diabetes Type II       |  |
| <input type="checkbox"/> Epilepsy                           |   |  |

**If you have ticked any of the above questions, please take this form to your doctor and ask for a clearance to exercise before starting any exercise program, OR sign below if you have already cleared the above condition with your doctor. Please provide details of any condition and related medication on the reverse of this form.**

### Have you ever had or do you have any of the following:

- |                                    |  |                                 |
|------------------------------------|--|---------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Muscular Pain | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Migraine  |  |                                 |

### Or Issues relating to: (please elaborate)

- |  |  |                                 |
|--|--|---------------------------------|
| <input type="checkbox"/> Neck problems | <input type="checkbox"/> Lower Back/Pelvis | <input type="checkbox"/> Cramps |
| <input type="checkbox"/> Knees         | <input type="checkbox"/> Ankles            |                                 |
| <input type="checkbox"/> Other         |  |                                 |

Are there any other conditions which may be reason to modify your exercise / nutrition program?

### Please read the following advice carefully:

- Work at a moderate level on your first visit and concentrate on learning to do the exercises properly. Do this each time you are taught a new exercise. On each visit you will progress a little more.
- Should you feel sharp pain or discomfort at any stage during your session, STOP immediately and advise your coach.
- Should you suffer from an injury, illness or any change in your condition in the future, please advise the instructor to update your records and modify your program accordingly.
- It is recommended by the American College of Sports Medicine that all males over 35 and females over 45 should have a medical assessment including an exercise E.C.G. and cholesterol count (including lipid count) prior to undertaking any exercise program.

### Statement:

I have answered the questions to the best of my ability and understand the advice that has been given to me.

Signed:

Dated: