PRE - EXERCISE HEALTH SCREEN QUESTIONNAIRE

(This information is confidential and will be stored with regard to Privacy Issues)

PERSONAL CONTACT DETAILS

NAME		
ADDRESS		POSTCODE
PHONE Home	Work	Mobile
DOB		
AGE		
OCCUPATION		
EMAIL		
NAME of EMERGENCY CONTACT & RELATIONSHIP TO YOU		
EMERGENCY CONTACT PHONE NUMBER		

MEDICAL CONTACT DETAILS

DOCTOR NAME (essential)

CONTACT DETAILS:

WARNING: Before embarking on a new program of fitness and exercise, you should consult your doctor. Refer also to our waiver and release from liability for other important information. (The waiver must be read and completed in conjunction with this Pre-screening Health Survey.)

In addition, please especially note, that if you are male over 45 or female over 55 years and NOT used to regular, moderate intensity exercise you must see your doctor BEFORE enrolling and partaking of services offered by Drop Zone Elite Fitness.

Pre-screening Health Form- HEALTH HISTORY STAGE 1:

PLEASE CIRCLE WHERE INDICATED AND PROVIDE OTHER DETAILS AS APPROPRIATE

• Are you male over 45 or female over 55 years & NOT used to regular, moderate intensity exercise? ***Yes/No***

• Have you been given advice from your doctor not to exercise? ***Yes/No***

• Have your parents or siblings had a heart attack, suffered from a cardiovascular / heart disease, stroke, raised cholesterol or sudden death before 65 years old? ***Yes/No***

• Do you have diabetes? ***Yes/No If Yes,*** please indicate if: IDDM OR NIDDM

If IDDM- how many years? _____

• Have you had a stroke? ***Yes/No***

• Do you take asthma medication? ***Yes/No***

• Or have difficulty breathing due to Bronchitis or Emphysema? ***Yes/No***

• Has your doctor ever said you have heart trouble / heart disease? ***Yes/No***

• Are you pregnant or given birth in the last 6 weeks? ***Yes/No/N.A.***

• Are you on any regular prescribed medication? ***Yes/No. If Yes, provide a brief description….***

_____

• Has your doctor told you that you have high blood pressure? ***Yes/No If Yes,*** what was your last reading for?

Systolic-_____Diastolic_____

• Do you have any pains or palpitations in the chest, heart, or surrounding areas, esp. during exercise? ***Yes/No***

• Do you feel faint or severe dizziness during exercise? ***Yes/No***

• Do you experience unusual fatigue, shortness of breath at rest or with mild exertion? ***Yes/No***

• Have you been awakened at night by an attack of shortness of breath or had an attack of shortness of breath following exercise? ***Yes/No***

• Do you get the feeling that your heart is beating faster, racing or skipping beats either at rest or during exercise? ***Yes/No***

• Do you get pain in your calves or lower legs during exercise which is not due to stiffness or soreness? ***Yes/No***

Do any of the following health conditions apply to you? ***Yes/No***

Please tick the circle of each one that applies to you

☐ Epilepsy	☐ Hernia	☐ Infections or infectious diseases
☐ Glandular Fever	☐ Rheumatic Fever	☐ Liver or kidney condition
☐ Stomach or Duodenal ulcer	☐ Cancer	

Have you been hospitalised recently? ***Yes/No*** Date: _____

Operation within the last 12 months ***Yes/No*** Date: _____

If you circle yes to any of the above please obtain medical clearance from your doctor to exercise.

Read carefully about Medical Clearances to Exercise under that following heading.

Medical Clearances to Exercise

This process involves asking your doctor:

- For clearance to begin exercising
- which activities you may safely participate in
- what specific restriction, if any, should apply to your condition and which activities and /or exercises you should avoid
- any activities that your doctor would particularly recommend to assist your particular condition.
- Identify when to exercise in relation to any medication currently being prescribed.

Please sign here if you have already cleared the above condition with your doctor

_____ Signature _____ Date Cleared

HEALTH HISTORY STAGE 2:

PLEASE CIRCLE WHERE INDICATED AND PROVIDE OTHER DETAILS AS APPROPRIATE

- Do you smoke cigarettes? ***Yes/No***
- Did you ever smoked? ***Yes/No*** If you circled yes, when did you give up? _____
- Do you have Gout, Osteoarthritis, Rheumatoid Arthritis, Ross River, Fibromyalgia, SLE or other from

of arthritis? ***Yes/No***

- Do you suffer from allergies and require an epipen? ***Yes/No***
- Do you have a pacemaker? ***Yes/No***

**** If you answered yes to any of the questions in this box, you are advised to get medical clearance to exercise.***

Please sign here if you have already cleared the above condition with your doctor

_____ Signature _____ Date Cleared

INJURY HISTORY:

PLEASE TICK THE CIRCLE WHERE INDICATED AND PROVIDE OTHER DETAILS AS APPROPRIATE

Have you ever had injury, surgery or joint replacement to your:

- Ankles? _____
- Knee? (torn ligaments or cartilage) _____
- Shoulder? _____
- Neck? (such as whiplash) _____
- Back / spinal disc injury?_____
- Elbows? _____
- Wrist? _____
- other? _____

EXERCISE HISTORY:

What are your current activity patterns?

Frequency: _____exercise sessions per week. Duration: _____ Minutes per session

Intensity: (circle one) sedentary moderate vigorous

History: (circle one) < 3 months 3-12 months < 12 months

Do you want to exercise at a moderate intensity (e.g. a brisk walk) or at a vigorous intensity (e.g. jogging)?

Please circle one: moderate vigorous

GOAL SETTING:

Why am I here today? Why do I want to exercise?

_____

_____

When I think of my body and health in 6-12 month's time, I would like it to be:

_____

_____

Thank you for completing this questionnaire.