EXERCISE SCREENING QUESTIONNAIRE

This page is **COMPULSORY** before commencing your exercise program.

Name			
Date of birth		**Age**	
Male/Female			
Phone (home)		**Phone (work)**	
Mobile		**Fax**	
Email			

1.	Has your doctor ever told you that you have a heart condition, or have you ever suffered a stroke?	☐ Yes	☐ No
2.	Do you ever experience unexplained pain in your chest at rest or during physical activity/exercise?	☐ Yes	☐ No
3.	Do you ever feel faint or have spells of dizziness during physical activity/exercise that causes you to lose balance?	☐ Yes	☐ No
4.	Have you had an asthma attack requiring immediate medical attention at any time over the last 12 months?	☐ Yes	☐ No
5.	If you have diabetes (type 1 or type II) have you had trouble controlling your blood glucose in the last 3 months?	☐ Yes	☐ No
6.	Do you have any diagnosed muscle, bone or joint problems that you have been told could be made worse by participating in physical activity/exercise?	☐ Yes	☐ No
7.	Do you have any other medical condition(s) that may make it dangerous for you to participate in physical activity/exercise?	☐ Yes	☐ No

IF YOU HAVE ANSWERED 'YES' to any of the questions, please seek guidance from your GP or appropriate allied health professional prior to undertaking physical activity/exercise.
IF YOU ANSWERED 'NO' to all of the 7 questions and you have no other concerns about your health, you may proceed to undertake physical activity/exercise.

Signature……

Date……

Have you ever been told by your doctor to avoid any type of exercise or strenuous activity? ☐ Yes ☐ No

If yes, please give details:

_____

Are you taking any prescribed medication? ☐ Yes ☐ No

If yes, please give details:

_____

Do you smoke? ☐ Yes ☐ No

If yes, how many per day?

_____

Do you consume alcohol? ☐ Yes ☐ No

If yes, how many drinks per day?

_____

How many hours do you sleep per night?

_____

Is this amount satisfactory?

_____

Do you have trouble sleeping?

_____

Your Own History

Condition	Yes/No/Not Sure		
Chest Pain	☐ Yes	☐ No	☐ Not Sure
Dizziness	☐ Yes	☐ No	☐ Not Sure
Fainting	☐ Yes	☐ No	☐ Not Sure
High Blood Pressure	☐ Yes	☐ No	☐ Not Sure
Joint Problems	☐ Yes	☐ No	☐ Not Sure
Pregnant	☐ Yes	☐ No	☐ Not Sure
Tuberculosis	☐ Yes	☐ No	☐ Not Sure
Bronchitis	☐ Yes	☐ No	☐ Not Sure
Asthma	☐ Yes	☐ No	☐ Not Sure
Diabetes	☐ Yes	☐ No	☐ Not Sure
Rheumatic Fever	☐ Yes	☐ No	☐ Not Sure
Nephritis	☐ Yes	☐ No	☐ Not Sure
Migraine	☐ Yes	☐ No	☐ Not Sure
Epilepsy	☐ Yes	☐ No	☐ Not Sure

Are you on any blood pressure medication? ☐ Yes ☐ No

If yes, please give details:

_____

Are you currently on any medication that could influence your ability to exercise? ☐ Yes ☐ No

If yes, please give details:

_____

Do you have any current injuries?	☐ Yes ☐ No
If yes, please state	