Name: _____

Medical Screening Questionnaire

Please answer the questions listed below. If you answer a "YES" to any of these questions, you must provide written medical clearance from your physician before you can begin an exercise program.

YES NO Has your doctor ever said that you have a heart condition and you should only do physical activity recommended by a doctor?

YES NO Do you have any pain in your chest and/or heart when doing physical activity?

YES NO Do you experience loss of consciousness or suffer from dizziness/fainting episodes?

YES NO Has your doctor ever told you that you have a bone or joint problem that might be aggravated or made worse by an increase in physical activity?

YES NO Are you currently taking medications for high blood pressure or for your heart?

YES NO Are you over 65 and NOT used to vigorous and intense exercise?

YES NO Is there any reason why you should not be able to begin a structured exercise program?

YES NO Would you describe your lifestyle as sedentary? (less than 30 minutes 3 days/week)

Are you or have you ever been under a physician's care for the following conditions:

Angina/Chest Pain Yes: _____ When: _____ No: _____
Abnormal Heart Beat Yes: _____ When: _____ No: _____
Heart Attack Yes: _____ When: _____ No: _____
Angioplasty Yes: _____ When: _____ No: _____
Epilepsy Yes: _____ When: _____ No: _____
Heart Surgery Yes: _____ When: _____ No: _____
Stroke Yes: _____ When: _____ No: _____
High blood pressure Yes: _____ Medication: _____ No: _____
Diabetes Yes: _____ Insulin: _____ No: _____
Asthma/Breathing Yes: _____ Inhaler used: _____ No: _____

Do you smoke Yes: _____ How much: _____ No: _____

Have you had or do you presently have any of the following conditions? (Check if yes.)

__ Rheumatic fever
__ Recent operation
__ Edema (swelling or ankles)
__ High blood pressure
__ Injury to back or knees
__ Low blood pressure
__ Seizures
__ Lung disease
__ Heat attack
__ Fainting or dizziness
__ Diabetes
__ High cholesterol
__ Orthopnea (the need to sit up to breathe comfortably) or paroxysmal (sudden, unexpected attack) nocturnal dyspnea (shortness of breath at night)
__ Shortness of breath at rest or with mild exertion
__ Chest pains
__ Palpitations or tachycardia (unusually strong or rapid heartbeat)
__ Intermittent claudication (calf cramping)
__ Pain, discomfort in the chest, neck jaw, arms, or other areas
__ Known heart murmur
__ Unusual fatigue or shortness of breath with usual activities
__ Temporary loss of visual acuity or speech, or short-term numbness/weakness in one side, arm, or leg

List any other medications NOT listed above:

_____
_____
_____
_____

Are there any other conditions or medical problems that may limit your physical activity?

_____
_____
_____
_____

ATTESTATION STATEMENT FOR MEDICAL SCREENING FORM

I attest that the above information is true and correct to the best of my knowledge. I further affirm that the information collected on the Medical Screening form will ONLY be used for the purpose of this initial assessment and general fitness programming recommendations. None of these recommendations should be interpreted as replacing, supplementing, or acting as medical advice.

Signature _____ Date _____

I hereby affirm that I am exercising with my physician's approval regarding a fitness program and have read and fully understand the above agreement. I attest that I have read and understand the above.

Signature _____ Date _____