

Medical Questionnaire

Contact Information

Name of Participant _____ Cell Phone _____ Alternate Phone _____

Address _____ City, State _____ Zip _____

Email address _____ Date of Birth _____ Gender _____

May we send text messages to for URGENT updates?
(You are responsible for text message charges that may be applied by cell phone provider) YES NO

Emergency Contact: _____
Name _____ Phone _____ Relationship to you _____

Physician Name: _____
Name _____ Phone _____ Address _____

Health History:

Step 1: Signs and Symptoms:

Do you experience (check all that apply):

- Chest discomfort with exertion
- Unreasonable breathlessness
- Dizziness, fainting, blackouts
- Ankle swelling
- Unpleasant awareness of a forceful, rapid, or irregular heart rate
- Burning or cramping sensations in lower legs when walking a short distance
- Known heart murmur

If you **marked** any of these statements under the symptoms, **STOP**, you should seek medical clearance before engaging in or resuming exercise. You may need to use a facility with **medically qualified staff**.

Step 2: Current Activity

Have you performed planned, structured, physical activity for at least 30 minutes at a moderate intensity on at least 3 days per week for the last 3 months?

- Yes No

Continue to step 3.

Step 3: Medical Conditions

Have you had or do you currently have (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> a heart attack | <input type="checkbox"/> angina |
| <input type="checkbox"/> heart surgery, cardiac catheterization, or coronary angioplasty | <input type="checkbox"/> lung disease: (type) _____ |
| <input type="checkbox"/> pacemaker/implantable cardiac defibrillator/rhythm disturbance | <input type="checkbox"/> stroke |
| <input type="checkbox"/> heart valve disease | <input type="checkbox"/> Alzheimer's/dementia |
| <input type="checkbox"/> heart failure | <input type="checkbox"/> muscle <input type="checkbox"/> bone <input type="checkbox"/> back <input type="checkbox"/> head/neck disorder <input type="checkbox"/> arthritis |
| <input type="checkbox"/> heart transplantation | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> congenital heart disease | <input type="checkbox"/> seizures |
| <input type="checkbox"/> diabetes – Type: _____ | <input type="checkbox"/> asthma |
| <input type="checkbox"/> renal disease | <input type="checkbox"/> family history of heart disease in parents or siblings prior to age 55 |
| <input type="checkbox"/> any conditions not list (please list): _____ | |

Continue to back page - Medications

Health History continued

Medications

Check those medications that you are currently taking:

- blood pressure medication
- asthma medication
- heart medication
- other: _____

Other symptoms

Do you have any physical condition, impairment, or disability, including joint or muscle problems that limit your activities?

- Yes No Unknown

Have you ever had angina or heavy pressure in your chest as a result of exercise, walking, or other physical activity such as climbing a flight of stairs?

- Yes No Unknown

Participant signature: _____ **Date:** _____

Print name: _____