COORDINATED FITNESS

Improving your Health

Health Screen Questionnaire

Name:	**DOB:**
Medicare / Ref Number:	
Address:	**Phone:**
Email Address:	
Emergency Contact Name:	**Phone:**
Health Fund & Number:	**Ref**

Stage 1 – Known Diseases (Medical Conditions)

1. 2. List the medications you take on a regular basis.

3. 4. Do you have diabetes? No Yes

a) b) If yes, please indicate if it is insulin dependent diabetes mellitus (IDDM) or non-insulin dependent diabetes mellitus (NIDDM) IDDM NIDDM

c) d) If IDDM, for how many years have you had IDDM? _____ Years

3. 4. Have you had a stroke? No Yes

5. 6. Has your doctor ever said you have heart trouble? No Yes

7. 8. Do you take asthma medication? No Yes

9. 10. Are you, or do you have reason to believe, you may be pregnant? No Yes

11. 12. Is there any physical reasons or injuries that affect you in your daily tasks? No Yes

If you answered yes to any questions Medical Clearance Needed

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Stage 2 – Signs and Symptoms

8.	9. Do you often have pains in your heart, chest, or surrounding areas, especially during exercise?	No	Yes
10.	11. Do you often feel faint or have spells of severe dizziness during exercise?	No	Yes
12.	13. Do you experience unusual fatigue or shortness of breath at rest or with mild exertion?	No	Yes
14.	15. Have you had an attack of shortness of breath that came on after you stopped exercising?	No	Yes
16.	17. Have you been awakened at night by an attack of shortness of breath?	No	Yes
18.	19. Do you experience swelling or accumulation of fluid in or around your ankles?	No	Yes
20.	21. Do you often get the feeling that your heart is beating faster, racing, or skipping beats, either at rest or during exercise?	No	Yes
22.	23. Do you regularly get pains in your calves and lower legs during exercise which are not due to soreness or stiffness?	No	Yes
24.	25. Has your doctor ever told you that you have a heart murmur?	No	Yes

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Stage 3 – Cardiac Risk Factors

26. Do you smoke cigarettes on a daily basis, or have you quit smoking within the past two years? No Yes

    If yes, how many cigarettes per day do you smoke (or did you smoke in the past two years)? _____ per day

27. Has your doctor ever told you that you have high blood pressure? No Yes

Blood Pressure _____ / _____ mmHg

Stage 4 – Physical Activity

Does your job involve sitting for a large part of the day? No Yes

What are your current activity patterns?

a) Frequency: _____ exercise sessions per week

b) Intensity: Sedentary Moderate Vigorous

c) History: < 3 months 3-12 months >12 months

d) Duration: _____ minutes per session

What types of exercise do you do?

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Your signature below indicates that:

- The information you have provided regarding your health is accurate to your level of understanding.
- That you have given information regarding the types of physical activity you are involved in and you have been given the chance to ask any questions that may concern you.
- That you are willing and want to be involved in an exercise program with Coordinated Fitness.
- You are taking responsibility for attending all doctor's appointments to gain medical clearance for participation.

Signed: ……
Date: ……