



## **HEALTH SCREEN QUESTIONNAIRE**

DATE \_\_\_\_\_

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ *if you are 55 or older you will need a medical clearance.*

### **SECTION 1 – MEDICAL CONDITIONS AND INJURIES**

**(If you answer yes to any of Section 1 you must have your doctor's approval to participate in an exercise activity or program.)**

1. DO YOU HAVE DIABETES? \_\_\_\_\_

2. IF SO IS IT INSULIN DEPENDENT (IDDM) AND FOR HOW LONG HAS IT BEEN INSULIN DEPENDENT? \_\_\_\_\_

3. HAVE YOU EVER SUFFERED FROM A STROKE? \_\_\_\_\_

4. HAS YOUR DOCTOR EVER SAID YOU HAD HEART TROUBLE?

\_\_\_\_\_  
\_\_\_\_\_

5. DO YOU SUFFER FROM ASTHMA OR EXERCISE INDUCED ASTHMA?  
IF SO DO YOU TAKE ANY MEDICATION?

\_\_\_\_\_

6. DO YOU HAVE ANY KNOWN ALLERGIES? IF SO, IS MEDICATION REQUIRED?

\_\_\_\_\_

7. ARE YOU, OR DO YOU HAVE REASON TO BELIEVE, YOU MAY BE PREGNANT?

*If you are pregnant you will need a medical clearance from your doctor.*

8. IF YOU HAVE RECENTLY GIVEN BIRTH, HAVE YOU BEEN CLEARED TO EXERCISE BY YOUR DOCTOR? \_\_\_\_\_

9. ARE THERE ANY OTHER MEDICAL CONDITIONS THAT PREVENT YOU FROM PARTICIPATING IN AN EXERCISE PROGRAM, (EG, CANCER, OSTEOPOROSIS, SEVERE ARTHRITIS, MENTAL ILLNESS, THYROID, EPILEPSY, ANAPHYLAXIS, KIDNEY OR LIVER DISEASE)? \_\_\_\_\_

\_\_\_\_\_

10. PLEASE LIST ALL MEDICATIONS THAT YOU ARE TAKING? \_\_\_\_\_

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11. PLEASE LIST IN DETAIL ANY INJURIES THAT MAY AFFECT YOU PARTICIPATING IN ANY FORM OF EXERCISE? \_\_\_\_\_

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**SECTION 2 – SIGNS AND SYMPTOMS**

*If you answer yes to two or more of the below questions in section 2 you will need a medical clearance.*

12. DO YOU OFTEN HAVE PAINS IN YOUR HEART CHEST OR SURROUNDING AREAS, ESPECIALLY DURING EXERCISE?

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13. DO YOU OFTEN FEEL FAINT OR HAVE SPELLS OF SEVERE DIZZINESS DURING EXERCISE?

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14. DO YOU EXPERIENCE UNUSUAL FATIGUE OR SHORTNESS OF BREATH AT REST OR WITH MILD EXERTION?

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15. HAVE YOU HAD AN ATTACK OR SHORTNESS OF BREATH THAT CAME ON AFTER YOU STOPPED EXERCISING? \_\_\_\_\_

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16. HAVE YOU BEEN AWAKENED AT NIGHT BY AN ATTACK OF SHORTNESS OF BREATH?

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17. DO YOU REGULARLY EXPERIENCE SWELLING OR ACCUMULATION OF FLUID IN OR AROUND YOU?

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18. DO YOU OFTEN GET THE FEELING THAT YOUR HEART SKIPS BEATS OR IS RACING UNNECESSARILY? \_\_\_\_\_

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19. DO YOU REGULARLY GET PAINS IN YOUR CALVES AND LOWER LEGS DURING EXERCISE WHICH ARE NOT DUE TO SORENESS OR STIFFNESS?

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20. HAS YOUR DOCTOR EVER TOLD YOU THAT YOU HAVE A HEART MURMUR?

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**SECTION 3 - CARDIAC RISK FACTORS**

*If you have answered yes to 2 or more of these questions in section 3 you will need a medical clearance*

20. DO YOU SMOKE CIGARETTES ON A DAILY BASIS, OR HAVE YOU QUIT SMOKING WITHIN THE PAST SIX MONTHS? \_\_\_\_\_

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21. A. HAS YOUR DOCTOR EVER TOLD YOU HAVE HIGH BLOOD PRESSURE?

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B. IS SO ARE YOU ON MEDICATION? \_\_\_\_\_

C. HAS YOUR DOCTOR APPROVED YOU TO EXERCISE \_\_\_\_\_

22. HAVE ANY OF YOUR IMMEDIATE FAMILY EVER SUFFERED FROM A HEART ATTACK OR A CARDIOVASCULAR DISEASE. *If you answered yes please answer the following questions, if no please go to question 23.*

- a) Was the relative male or female? \_\_\_\_\_
- b) At what age did this occur? \_\_\_\_\_
- c) Did this person die suddenly? \_\_\_\_\_

23. HAVE YOU EXPERIENCED MENOPAUSE BEFORE THE AGE OF 45? \_\_\_\_\_  
IF YES, DO YOU TAKE HORMONE REPLACEMENT MEDICATION \_\_\_\_\_

24. WHAT IS YOUR BLOOD PRESSURE?  
SYSTOLIC BP (HIGH VALUE) \_\_\_\_\_ mmHg  
DIASTOLIC BP (LOW VALUE) \_\_\_\_\_ mmHg

*If the systolic measurement is 140 or greater and/or the diastolic is 90 or greater on two separate occasions you will need a medical clearance.*

#### SECTION 4 – EXERCISE INTENTIONS

25. DOES YOUR JOB INVOLVE SITTING FOR A LARGE PART OF THE DAY?  
\_\_\_\_\_

26. 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

27. WHAT TYPES OF EXERCISES DO YOU DO?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_ HAVE ANSWERED THIS HEALTH SCREEN QUESTIONNAIRE HONESTLY, AND AM AWARE THAT THIS FORM WILL BE VIEWED BY THE TRAINERS OF PIONEER TRAINING I AND WILL NOTIFY PIONEER TRAINING IN WRITING IF ANY OF THE ABOVE DETAILS CHANGE.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_