



## Pre-Exercise Questionnaire

### Personal Details

Name:.....  
 Address:.....  
 ..... P/C:.....  
 Phone (H): .....  
 (W): .....  
 (M):.....

Occupation:.....  
 DOB: DD/MM/YYYY Sex: M / F  
 Doctors Name:.....  
 Doctors Phone:.....  
 Emergency Contact:.....  
 Phone:.....

1) List ALL medications you are regularly taking and reasons for taking them: .....

.....

.....

2) Do you have/had or been told by a doctor that you are at risk of:

High Blood Pressure	Y/N
High Cholesterol	Y/N
Cardiovascular Disease	Y/N
Lung Disorder	Y/N

3) Do you have diabetes? Y/N

If yes, what type of diabetes  
 Type 1    Type 2  
 How long have you had diabetes .....

4) Have you ever had pain or pressure, either at rest or during exercise:

In the middle of, or the left side of the chest	Y/N
In the neck or jaw region	Y/N
In the left shoulder or down the left arm	Y/N

5) Have you in the past 12 months, had an attack of shortness of breath that came on when you were not doing anything strenuous? Y/N

6) Do you experience swelling or accumulation of fluid around the ankles? Y/N

7) Do you regularly get pain in the calves and lower limbs during exercise not due to soreness or stiffness? Y/N

8) Do you have a close relative who has had a stroke, heart attack or other cardiovascular disease?

If yes what relation is this person.....  
 At what age did he/she suffer this disease.....  
 Did your relative die suddenly as a result of the disease? Y/N

9) Have you ever smoked cigarettes? Y/N

If yes, do you currently smoke Y/N  
 Yes, but stopped <5 years ago Y/N  
 Stopped >5 years ago Y/N

10) Have you ever experienced a brain or spinal injury that has required medical attention? Y/N

Explain:.....

11) Have you ever suffered any nervous system injury, such as lesion or damage to a nerve, numbness or pins and needles? Y/N

Explain:.....

12) Have you experienced any unusual muscular or joint pain in the past 12 months? Y/N  
 Explain:.....

Fainting Y/N  
 Convulsions Y/N  
 Seizures Y/N  
 Dizzy Spells Y/N

13) Have you sustained a fracture or undergone joint replacement surgery which causes you on-going problem? Y/N  
 Explain:.....

17) Have you undergone any surgery in the past 12 months? Y/N  
 Explain:.....

14) Do you or your immediate family suffer from any chronic musculoskeletal problems such as osteoporosis and osteoarthritis? Y/N  
 Who/where:.....

18) Are you or have you received treatment from an allied health professional in the last 6 months? (eg Chiro, Physio, Osteopath) Y/N  
 Explain:.....

15) Do you have any condition that may require special consideration when exercising or that would prevent you from exercising? (eg cancer, liver/kidney/thyroid disease, HIV/AIDS, Parkinson's Disease, Multiple Sclerosis, Chronic Fatigue Syndrome etc) Y/N  
 Explain:.....

19) Are you, or do you believe you could be pregnant? Y/N

20) Did you experience menopause before the age of 45? Y/N

16) Do you experience or have you ever experienced: Epilepsy Y/N

21) Current Activity Patterns (please circle one in each column):

<i>Intensity</i>	<i>Frequency</i>	<i>Duration</i>	<i>History</i>
Nil	<2 times/week	<20 mins	<3 months
Moderate (walking)	2-3 times/week	20-40 mins	3-6 months
High (jogging)	3-4 times/week	40-60 mins	6-12 months
Vigorous (running)	>4 times/week	>60 mins	>12 months

I have read, understood and answered this questionnaire honestly. I will notify the treating Exercise Physiologist if my health status changes or medical condition changes in relation to the above questions. If at any stage I experience chest, leg/arm pain, shortness of breath or dizziness while exercising I will immediately notify the supervising Exercise Physiologist.

NAME:.....

SIGNED:..... DATE:.....