Print Name: _____
Phone Number or Email Address: _____

Pre-Physical Activity Screening

The Pre-Physical Activity Screening is designed to help you help yourself. Many health benefits are associated with regular exercise, and the completion of this questionnaire is a sensible first step to take if you are planning to increase the amount of physical activity in your life.

For most people, physical activity should not pose any serious problem or hazard. The questionnaire is designed to identify those adults for whom initiating a physical fitness program should have medical advice concerning the type of activity most suitable for them.

Carefully complete the following questionnaire and check the ☐ YES or NO opposite the question if it applies to you. Complete each section of questions and return completed form to (contact's name). If needed, you can also send via U.S. Mail or secured internal mail to: (contact's name and address or mail station)

Section A

YES NO

☐ ☐ 1. Has a doctor ever said you have heart trouble or are you taking medication(s) for a heart condition?
☐ ☐ 2. Do you frequently have pains in your chest or surrounding areas?
☐ ☐ 3. Do you have shortness of breath or shortness of breath with mild exertion?
☐ ☐ 4. Do you often feel faint or have spells of severe dizziness?
☐ ☐ 5. Do you have difficulty breathing when lying down or sudden breathing problems during the night?
☐ ☐ 6. Do you have rapid throbbing or fluttering of the heart?
☐ ☐ 7. Do you have severe pain in leg muscles during walking?
☐ ☐ 8. Do you have a known heart murmur?
☐ ☐ 9. Do you have a seizure disorder or convulsions?
☐ ☐ 10. Are you pregnant?

Checking "Yes" to any of the above questions will require a Physician's Release and Clearance Form before beginning an exercise program.

Section B

YES NO

☐ ☐ 11. Have you ever been diagnosed with high blood pressure or systolic blood pressure >140 mmHg or diastolic blood pressure > 90 mmHg on two separate occasions, or are you taking blood pressure medication?
☐ ☐ 12. Has your doctor ever said your cholesterol level was too high? (≥ 240mg/dl)
☐ ☐ 13. Do you currently smoke or have you quit within the past 6 months?
☐ ☐ 14. Do you have diabetes mellitus or physician diagnosed hypoglycemia?
☐ ☐ 15. Have you been diagnosed by a physician as being clinically obese?
☐ ☐ 16. Do you have a sedentary lifestyle? (Moderately active < 3 days per week)

Checking "Yes" to two or more of the above questions will require a Physician's Release and Clearance Form before beginning an exercise program.

Section C

YES NO

☐ ☐ 17. Has a doctor ever told you that you have a musculoskeletal problem such as arthritis, back, knees, hands, etc. that has been aggravated by exercise, or might be made worse with exercise?

Please list condition(s)_____

☐ ☐ 18. Have you had any type of surgery within the last 12 months?

Please identify_____

☐ ☐ 19. Do you know of any reason why you should not do physical activity?

Please list reason(s)_____

☐ ☐ 20. Are you currently taking any medication(s)?

Please list medication(s)_____

Checking "Yes" to one or more of the above questions may require a Physician's Release and Clearance Form before beginning an exercise program.

I verify that I have answered all questions truthfully and to the best of my knowledge. If I have a change in my health status or a significant medical event during the course of my physical activity program, I will notify the fitness center staff immediately and provide information as requested. I understand that my Fitness Center membership may be terminated if it has been determined that a change in my health status has made it unsafe to continue my physical activity program.

Signed: _____ **Date:** _____