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Pre-Exercise Questionnaire - Medical

Personal Information

Name: ______________________________ M / F Age: ________ D.O.B.: _____/_____/_____

Address: ____ PCode: ________

Ph: Home ____________________ Work ____________________ Mobile ______________________

Fax: ____________________ E-mail: ____

Occupation: ______________________________ Employer: ______________________________

Emergency Contact: __________________________ Phone: ____________________ ____________________

How did you find out about Personal Best?

- □ Signage
- □ Website
- □ Yellow Pages
- □ Yellow Pages on-line
- □ Flyer
- □ Referral (____________________)
- □ Lead Box
- □ Newspaper
- □ Radio
- □ Television
- □ Former Client
- □ Other ______________________

Office use only

Key Tag #: _____________

Date Commenced: _____/_____/_____

PRIVACY POLICY

The attached questionnaire asks personal information about your health, fitness and lifestyle to ensure that both a safe and effective service can be provided. Personal Best has a comprehensive privacy policy governing how any personal information collected will be used. For further information, go to www.personalbest.net.au

Family Medical History

A reliable family history provides useful information regarding your health. In the space below please list the medical histories of your immediate family including parents, brothers, sisters and grandparents.

CONDITION	YES	NO	RELATION TO YOU	AGE AT ONSET	AGE AT DEATH	CAUSE OF DEATH
HIGH CHOLESTEROL						
HIGH BLOOD PRESSURE						
ANGINA						
HEART ATTACK						
STROKE						
HEART DISEASE						
HEART SURGERY						
VASCULAR SURGERY (e.g. varicose veins)						
CANCER						
DIABETES						
OBESITY						

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Personal Medical History

Please read the following and tick accordingly. If you answer YES to any of the questions, please specify where indicated.

Cardiovascular System

YES	NO	
☐	☐	Have you ever had a heart attack or stroke? Year: ___________
☐	☐	Do you have or have you ever had angina?
		☐ past - but not now ☐ at present
☐	☐	Do you have or have you ever had any other type of heart disease or heart abnormality?
		If YES, please specify: ___________
☐	☐	Do you ever experience chest pains or chest discomfort?
☐	☐	If so, is the pain related to physical activity?
		If YES, please explain: ___________
☐	☐	Do you ever experience dizziness, fainting or black-outs?
☐	☐	Do you ever experience palpitations, extra or skipped heart beats?
☐	☐	Do you ever experience tingling or numbness in the extremities? (i.e. arms, legs)
☐	☐	Do you ever experience fluid retention/odema? (i.e. arms, legs)
☐	☐	Do you have any bleeding disorders (eg. Haemophilia)?
☐	☐	Do you have or have you ever had any peripheral vascular problems?
		☐ past - but not now ☐ at present
☐	☐	Do you have or have you ever had high blood pressure?
		☐ past - but not now ☐ at present BP: ______/______
☐	☐	Do you have or have you ever had high blood cholesterol?
		☐ past - but not now ☐ at present Level: __________

Have you ever had any of the following?

YES	NO		
☐	☐	Rheumatic Fever	Year __________
☐	☐	Phelbitis	Year __________
☐	☐	Emboli	Year __________
☐	☐	Anaemia	Year __________

Have you ever had any of the following investigations?

YES	NO		
☐	☐	Resting ECG (Electrocardiogram)	Year __________
☐	☐	Exercise Stress Test (ECG)	Year __________

Respiratory System

YES	NO	
☐	☐	Do you have any lung problems or breathing difficulties?
		If YES, please specify: ___________
☐	☐	Have you ever been diagnosed as having emphysema?
☐	☐	Have you ever been diagnosed as having bronchitis?
☐	☐	Have you ever been diagnosed as having asthma?
		If YES, what level of asthma: ☐ mild ☐ moderate ☐ severe
		What medication and dosage are you taking? ___________
☐	☐	Do you experience shortness of breath?
		If YES, under what conditions: ___________

Have you ever had any of the following?

YES	NO		
☐	☐	Pneumonia	Year __________
☐	☐	Pleurisy	Year __________
☐	☐	Tuberculosis	Year __________
☐	☐	Coughed up blood	Year __________

Have you ever had any of the following investigations?

☐	☐	Lung Function Test	Year __________
☐	☐	Chest X-Ray	Year __________

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Musculo-skeletal System

YES NO

☐ ☐ Have you ever broken any bones? If YES, please specify: ____________________

☐ ☐ Have you ever been diagnosed as having osteoporosis?
If YES, in which bones/areas: ____________________

☐ ☐ Do you have or have you ever experienced any back/neck problems and/or pain?
☐ past - but not now ☐ at present
If YES, in which areas: ☐ Neck ☐ Upper Back ☐ Mid-Back ☐ Lower back
☐ Pelvis ☐ Coccyx ☐ Other __________

☐ ☐ Do you experience any other bone or joint pain? (ie. arthritis, aches and pains)
If YES, please specify the joint or bones affected: ____________________

☐ ☐ Do you experience any limited range of motion in any joint?
If YES, please specify the joint: ____________________

☐ ☐ Do you have or have you ever had any muscular injury?
☐ past - but not now ☐ at present

If YES, please specify areas and treatment received: ____________________

____

____

____

☐ ☐ Do you experience any muscle pain?
If YES, please specify the muscles affected: ____________________

☐ ☐ Have you ever suffered any major soft tissue injury? (e.g. torn muscle, ligaments, cartilage etc).

If YES, please areas and treatment received: ____________________

____

____

____

General Conditions

Do you or have you ever suffered from any of the following?

YES	NO			
☐	☐	Thyroid gland problem	☐ past - but not now	☐ at present
		If YES, please describe: ____________________		
☐	☐	Diabetes	☐ past - but not now	☐ at present
		If YES, please specify any medication: ____________________		
☐	☐	Allergies	☐ past - but not now	☐ at present
		If YES, please specify: ____________________		
☐	☐	Epilepsy or fits	☐ past - but not now	☐ at present
☐	☐	Head injuries	☐ past - but not now	☐ at present
☐	☐	Migraines &/or chronic headaches	☐ past - but not now	☐ at present
☐	☐	Black-outs, fainting	☐ past - but not now	☐ at present
☐	☐	Psychological disorders	☐ past - but not now	☐ at present
☐	☐	Infectious Diseases or viruses, eg HIV, Hepatitis	☐ past - but not now	☐ at present
☐	☐	Glandular Fever or Chronic Fatigue Syndrome	☐ past - but not now	☐ at present
☐	☐	Hernia	☐ past - but not now	☐ at present
☐	☐	Gout	☐ past - but not now	☐ at present

Pre-Exercise Questionnaire - Medical

Current Medical and Health

Doctor: ____________________ Phone: _______________

When did you have your last medical exam? _____/_____/_____

YES	NO	
☐	☐	Are you currently being treated for any medical or health condition? If YES, please specify: ______________________________
☐	☐	Are you currently taking any prescribed medication or supplements? If YES, please outline what you are taking and the reason for taking them. ____________________ ______________________________
☐	☐	Are there any contraindications with your medication? If YES, please specify: ______________________________
☐	☐	Are you allergic to any medications or supplements? If YES, please specify: ______________________________
☐	☐	Do you have any medical conditions that affect your balance? If YES, please specify: ______________________________
☐	☐	Are there any other conditions that may limit your activity? If YES, please specify: ______________________________

Operations/ Investigations

YES	NO	
☐	☐	Have you ever had an operation or been admitted to hospital?

If yes, please outline (include all major & minor operations/investigations such as arthroscopy, appendectomy):

YEAR OF OPERATION OR ADMISSION	REASON FOR ADMISSION	ANY POST-ADMISSION COMPLICATIONS

Section for Females only

YES	NO	
☐	☐	Have you given birth in the last 3 months? If YES, when month/ year? ____________________
☐	☐	Are you currently pregnant? If YES, how many months pregnant? ___________