Take Care Health Solutions – Pre-Exercise Screening Questionnaire

Please answer all questions and return the completed form to the fitness center staff. To protect your privacy please return this form in-person to the fitness center staff. If this is not possible, please mark confidential and send via U.S. Mail to:

The information obtained during the member entry process is designed to optimize safety and foster attainment of personal goals. All information will be kept strictly confidential and will only be available to Take Care Health Systems personnel unless otherwise authorized in writing by the individual.

Name:	Male / Female (please circle)	Date of Birth:	Today's date:
Work Address:	Work Phone:	Member ID #:	Age:
Emergency Contact:	Phone:	Eve. Phone:	
Doctor's Name:	Phone:	Date of last physical:	

Please circle "3" in the box(es) below on the right if the item applies to you, and circle "0" if it does not apply to you.

MEN: Are you a **male age 45 or above?**	0 3
WOMEN : Are you a **female age 55 or above**?	0 3
Are you pregnant?	0 3
HEART/VASCULAR – ***please check any that apply:***	0 3

❑ cardiac disease
❑ peripheral vascular disease
❑ dizziness or fainting
❑ ankle edema
❑ cerebrovascular disease/stroke
❑ angina, pain in the chest, neck, jaw, or arms (at rest or on exertion)
❑ shortness of breath or unusual fatigue
❑ difficulty breathing lying down that disappears after sitting up
❑ leg pain or cramping while walking that disappears when you stop
❑ irregular heartbeats or palpitations
❑ heart murmur/mitral valve prolapse

METABOLIC DISEASE – ***please check any that apply:*** 0 3

❑ diabetes
❑ kidney disease
❑ liver disease
❑ thyroid disorder
❑ other metabolic disorders ___________________________

PULMONARY DISEASE – ***please check any that apply:*** 0 3

❑ chronic obstructive pulmonary disease/emphysema
❑ asthma
❑ cystic fibrosis
❑ interstitial lung disease
❑ other pulmonary disease: ___________________________

SEIZURE DISORDERS OR CONVULSIONS: 0 3

Please enter total of above column here: [ ]

Please continue to the top of the column on the right ↗

Please circle "1" in the box(es) below on the right if the item applies to you, and circle "0" if it does not apply to you.

Has your father, brother, or son before 55 years of age, or your mother, sister, or daughter before 65 years of age, had a history of heart disease?	0 1
Do you currently smoke, or have you quit within the past 6 months?	0 1
Have you had systolic blood pressure $\geq$ 140 mm Hg or diastolic $\geq$ 90 mm Hg, confirmed by measurements on at least two separate occasions, or are you on antihypertensive medication?	0 1
Have you had an LDL cholesterol reading > 130 mg/dl^{-1} or HDL cholesterol reading < 40mg/dl^{-1}, or are you on lipid lowering medication? (or, if total cholesterol is all that is available use > 200 ml/dl^{-1})	0 1
Have you had fasting blood glucose of $\geq$ 100 mg/dl^{-1} confirmed by measurements on at least two separate occasions?	0 1
Do you have a BMI of > 30 kg/m^2 or waist girth of > 40" (men) >34.6"(women), or a waist/hip ratio of $\geq$ .95 (men) $\geq$ .86 (women)?	0 1
Are you sedentary? (i.e. less than 30 min. of moderate activity most days of the week?)	0 1

If the following protective risk factor for coronary disease applies to you please enter a "-1" in the box on the right:

Do you have a HDL > 60 mg/dl^{-1}? *(HDL >60mg/dl^{-1} erases one of the above risk factors for heart disease)*	0 -1

Please enter total of above column here: [ ]

TOTAL: Enter total of left and right columns: [ ]

If the TOTAL of both columns above = 2 or more, you must have your doctor complete and submit a Physician's Clearance Form (see reverse side of this page) prior to joining the fitness center.

☑ **Please check if you have any of the following conditions. These conditions may require physician's clearance.**

❑ Major surgery or hospitalization within the past 6 months. Please explain: ____________________
❑ Musculoskeletal problems (e.g. arthritis, back, knees, etc.): ____________________
❑ Prescribed medications, please list those that you are taking: ____________________
❑ Do you have any other medical conditions or physical limitations that may affect participation in an exercise program?

*Please explain:*____________________

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 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:** ______________