



Niagara College

Lifestyle & Medical History Questionnaire

Stretch & Flex

Medical Information

Please check any that apply to you (past or present) and list any important information about your condition:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Irritable bowel syndrome (IBS)
<input type="checkbox"/> Angina	<input type="checkbox"/> Low Blood pressure	<input type="checkbox"/> Menopausal symptoms
<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pregnant
<input type="checkbox"/> Cancer	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Polycystic ovary syndrome (PCOS)
<input type="checkbox"/> Chronic sinus condition	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Hypo/hyperthyroidism	<input type="checkbox"/> Skin problems
<input type="checkbox"/> COPD	<input type="checkbox"/> Intestinal problems	<input type="checkbox"/> Respiratory disease

Type 1 Diabetes

Type 2 Diabetes

Specify allergies:

Describe any other health condition that is not listed:

Any important information about your condition (if it applies):

Please list any injuries that may interfere with exercising (past or present):

Please list any major surgeries:

Family History

Has anyone in your immediate family been diagnosed with the following?

- Heart Disease If yes, what relation: _____
- High cholesterol If yes, what relation: _____
- High blood pressure If yes, what relation: _____
- Cancer If yes, what relation: _____
- Diabetes If yes, what relation: _____
- Osteoporosis If yes, what relation: _____
- Stroke If yes, what relation: _____

Medications

Are you taking any prescribed medications? If yes, what medications?

Do these interact with any physical activity?

Do you take any over-the-counter medication? If yes, what medication(s)?

Lifestyle and Habits

Do you participate in any structured physical activity? Yes No

If so, please describe:

Minutes of cardiovascular activity & times per week:

At what intensity are the cardiovascular sessions:

Low Moderate High

Strength-training sessions & times per week:

Minutes of flexibility training & times per week:

Minutes of sports per week:

List sport(s):

Accuracy of Information

I certify that the above medical information is correct to my knowledge.

I agree

Print Name

Witness Print Name

Signature

Witness Signature

Date

Date