

► Screening Questionnaire

PLEASE FILL OUT ALL INFORMATION BELOW

Name:	Date of Birth:	Age:
Address:		
City, State, Zip:		
Home Phone:	Work Phone:	
Employer:	Occupation:	

PLEASE CHECK THE BOX FOR THE APPROPRIATE ANSWER

Has your doctor ever said you have heart trouble?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had angina pectoris, sharp pain, or heavy pressure in your chest as a result of exercise, walking, or other physical activity such as climbing stairs? <i>(Note: This does not include the normal out of breath feeling that results from normal activity)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you experience any sharp pain or extreme tightness in your chest when you are hit with a cold blast of air?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever experienced rapid heart action or palpitations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had a real or suspected heart attack, coronary occlusion, myocardial infarction, coronary insufficiency, or thrombosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had rheumatic fever?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have diabetes, hypertension, or high blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does anyone in your family have diabetes, hypertension, or high blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has more than one blood relative (parent, sibling, first cousin) had a heart attack or coronary artery disease before the age of 60?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever taken medications or been on a special diet to lower your cholesterol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever taken digitalis, quinine, or any other drug for your heart?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever taken nitroglycerine or any other tablets for chest pain—tablets you take by placing under the tongue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you overweight?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you under a lot of stress?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you drink excessively?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you smoke cigarettes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a physical condition, impairment or disability, including a joint or muscle problem, that should be considered before you undertake an exercise program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you more than 65 years old?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you more than 35 years old?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you exercise fewer than three times per week?	<input type="checkbox"/> Yes	<input type="checkbox"/> No