



# Screening Questionnaire



Name: Date of Birth: Age:

Address:

City, State, Zip:

Home Phone: Work Phone:

Employer: Occupation:

Has your doctor ever said you have heart trouble?  Yes  No

Have you ever had angina pectoris, sharp pain, or heavy pressure in your chest as a result of exercise,  Yes  No

walking, or other physical activity such as climbing stairs? *(Note: This does not include the normal out of breath feeling that results from normal activity)*

Do you experience any sharp pain or extreme tightness in your chest when you are hit with a  Yes  No

cold blast of air?

Have you ever experienced rapid heart action or palpitations?  Yes  No

Have you ever had a real or suspected heart attack, coronary occlusion, myocardial infarction,  Yes  No

coronary insufficiency, or thrombosis?

Have you ever had rheumatic fever?  Yes  No

Do you have diabetes, hypertension, or high blood pressure?  Yes  No

Does anyone in your family have diabetes, hypertension, or high blood pressure?  Yes  No

Has more than one blood relative (parent, sibling, first cousin) had a heart attack  Yes  No or coronary artery disease before the age of 60?

Have you ever taken medications or been on a special diet to lower your cholesterol?  Yes  No

Have you ever taken digitalis, quinine, or any other drug for your heart?  Yes  No

Have you ever taken nitroglycerine or any other tablets for chest pain—tablets  Yes  No you take by placing under the tongue?

Are you overweight?  Yes  No

Are you under a lot of stress?  Yes  No

Do you drink excessively?  Yes  No

Do you smoke cigarettes?  Yes  No

Do you have a physical condition, impairment or disability, including a joint or  Yes  No muscle problem, that should be considered before you undertake an exercise program?

Are you more than 65 years old?  Yes  No

Are you more than 35 years old?  Yes  No

Do you exercise fewer than three times per week?  Yes  No