Pre exercise questionnaire

	No	Yes
Has your Doctor ever said that you have a heart condition and that you should only do physical activity recommended by a Doctor?	☐	☐
Do you feel pain in your chest when you do physical activity?	☐	☐
In the past month had you had chest pain when you were not doing physical activity?	☐	☐
Do you lose your balance because of dizziness or do you ever lose consciousness?	☐	☐
Do you have a bone or joint problem that could be made worse by a change in your physical activity?	☐	☐
Do you know of any other reason why you should not do physical activity?	☐	☐
Is your Doctor currently prescribing drugs for your blood pressure or heart condition or any other medication that will affect you when taking part in physical exertion?	☐	☐
If female, have you been pregnant in the last 6 months?	☐	☐
Do you or your family have a history of:		
Heart Conditions	☐	☐
Blood Pressure	☐	☐
Breathing problems including asthma, bronchitis, emphysema	☐	☐
Bowel Problems	☐	☐
Sweating (including night sweats)	☐	☐
Headaches	☐	☐
Unexpected weight loss/gain	☐	☐
Thyroid	☐	☐
Have you recently had:		
Surgery	☐	☐
Cold / Flu symptoms	☐	☐

If you answered YES to one or more questions
Check with the Fitness trainer and consult with your doctor.

Note: If you are or may be pregnant, talk to your Doctor before you start to become more active.

Declaration
We collect the above information about your health and medical history so that we have as much relevant information as possible to provide you with a suitable, safe exercise programme. We will use our best endeavours to hold this information securely in recognition of its confidential nature, and it is only seen by our Fitness professionals. Unless we are legally required to do so, it will not be disclosed to any third parties without your written consent. By signing below, you consent to us holding this information for these purposes.

I certify that I have answered all the above questions correctly and to the best of my knowledge and I am free from any medical conditions which may be aggravated by physical exertion. I confirm that I will immediately advise a member of the *Definition team* of any changes in my medical circumstances.

Print Name ______________________ Date ______________________

Signature ______________________ Staff ______________________