

OA/UNE Human Performance Lab

Exercise Risk Assessment Form

Name _____ Gender _____ Age _____

Address _____

E-mail Address _____

Phone / Fax _____

Please provide the following information as accurately and completely as possible so that we may assess if you are a "suitable candidate" to begin an exercise program, or to complete a graded exercise test, body composition test, or other fitness test.

Known Cardiovascular, Pulmonary or Metabolic Disease

Have you been diagnosed with any of the following diseases/disorders/conditions or had any of the following procedures?

- Yes No Myocardial infarction ("heart attack") _____
- Yes No Stroke or ischemic attack ("mini-stroke") _____
- Yes No Heart bypass surgery or other heart surgery _____
- Yes No Coronary catheterization and/or angioplasty _____
- Yes No Abnormal ECG (tachycardias, heart blocks, etc.) _____
- Yes No Other cardiovascular disease/disorder (aneurysm, etc.) _____
- Yes No Chronic obstructive pulmonary disease (COPD, etc.) _____
- Yes No Diabetes (insulin dependent, non-insulin dependent, etc.) _____
- Yes No Hyperlipidemia (high LDL, low HDL, etc.) _____

Comments:

Signs or Symptoms Suggestive of Cardiovascular and Pulmonary Disease

Have you experienced any of the following?

- Yes No Pain/discomfort in your chest, jaw or arms _____
- Yes No Shortness of breath at rest or mild exertion _____
- Yes No Dizziness or fainting spells _____
- Yes No Difficulty breathing while lying down _____
- Yes No Swelling of your ankles _____
- Yes No "Skipped" heart beats or a "racing" heart beat _____
- Yes No Occasional leg pain, especially while walking _____
- Yes No Heart murmur _____
- Yes No Fatigue or shortness of breath with usual activities _____



OA/UNE Human Performance Lab

Comments:

Risk Factors of Cardiovascular Disease

Do you have a personal history of any of the following?

- | | | |
|--|---|-----------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cigarette smoking | Packs/day _____, yrs smoked _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Obesity or highly overweight | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Physical inactivity | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure (over 140/90 mmHg) | Blood pressure _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | High cholesterol (over 200 mg/dl) | Cholesterol _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes or high blood sugar (over 110 mg/dl) | Blood glucose _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Family history of heart attack/stroke, at young age | |

Comments:

What is your current level of physical activity and exercise?

(Frequency, duration, types of activity, etc.)

Physical Activity Readiness Questionnaire (PAR-Q)

- Yes No Has your doctor ever said you have a heart condition and should only do physical activity recommended by a doctor?
- Yes No Do you feel pain in your chest when you do physical activity?
- Yes No In the past month, have you had chest pain when you were not physically activity?
- Yes No Do you lose your balance because of dizziness or do you ever lose consciousness?
- Yes No Do you have a bone/joint problem that could be made worse by a change in your physical activity?
- Yes No Is your doctor currently prescribing drugs for your blood pressure or heart condition?
- Yes No Do you know of any other reason why you should not do physical activity?

Comments:

OA/UNE Human Performance Lab

Drugs/Medications

Please list any prescription or over the counter (OTC) drugs/medications you are currently taking.

Drug/Medication

Purpose/Reason for Taking

Doctor / Health Plan Information (Must be completed)

Name / Group _____

Phone / Fax _____

Address

In Case of Emergency (Must be completed)

Name

Phone

Note to Applicant

This health history information will be used to determine your "risk category" (as established by the American College of Sports Medicine) for participation in a graded exercise test. This information will be kept confidential to the extent provided by law and will be released to no other party other than your personal physician or primary care provider without your written consent.

Depending on your "risk category" you may be asked to provide further Medical Clearance prior to the Graded exercise test or you may be excluded from participating. If you are excluded from participating, you will be referred to an appropriate facility for services.

Upon completion of this form, I declare and understand the following:

Initial _____

I have completed this health history to the best of my recollection and have not knowingly withheld any information concerning my health history.

Initial _____

I understand that this information will be used to assess my "risk category" for my participation in a graded exercise test.

Initial _____

I understand that I may be excluded from a fitness assessment based on my exercise risk or that my participation may in some way be restricted or altered.

Signature: _____

Date: _____