American Heart Association/American College of Sports Medicine
Health/Fitness Pre-Participation Screening Questionnaire

*If you marked **any of the statements in this section**, **consult your physician** or other appropriate healthcare provider before engaging in exercise. You may need to use a facility with a **medically qualified staff**.*

You have had:
___ A heart attack
___ Heart surgery
___ Cardiac catheter (-ization)
___ Coronary angioplasty (PTCA)
___ Pacemaker/implantable cardiac defibrillator/rhythm disturbance
___ Heart valve disease
___ Heart failure
___ Heart transplantation
___ Congenital heart disease

Symptoms
___ You experience chest discomfort with exertion.
___ You experience unreasonable breathlessness.
___ You experience dizziness, fainting, blackouts.
___ You take heart medications.
___ Irregular heart rate (Dysrhythmias)

Other health issues:
___ You have diabetes
___ You have or asthma other lung disease.
___ You have burning or cramping in your lower legs when walking short distances.
___ You have musculoskeletal problems that limit your physical activity.
___ You have concerns about the safety of exercise.
___ You take prescription medication(s).
___ You are pregnant.

Cardiovascular risk factors *If you marked **two or more** of the statements in this section, you should consult your physician or other appropriate healthcare provider before engaging in exercise. You might benefit by using a facility with a **professionally qualified exercise staff** to guide your exercise program.*

___ You are a man older than 45 years.
___ You are a woman older than 55 years, you have had a hysterectomy, or you are postmenopausal.
___ You smoke, or have quit within the previous 6 months.
___ Your BP is greater than 140/90.
___ You don't know your BP.
___ You take BP medication.
___ Your blood cholesterol level is >200 mg/dL.
___ You don't know your cholesterol level.
___ You have a close blood relative - heart attack before age 55 (father/brother), age 65 (mother/sister).
___ You are physically inactive (i.e., less than 30 min. of physical activity on at least 3 days per week).
___ You are more than 20 pounds overweight.
___ None of the above is true.

You should be able to exercise safely without consulting your physician or other healthcare provider in a self-guided program or almost any facility that meets your exercise program needs.

Balady et al. (1998). AHA/ACSM Joint Statement: Recommendations for Cardiovascular Screening, Staffing, and Emergency Policies at Health/Fitness Facilities. Medicine & Science in Sports & Exercise, 30(6). (Also in: ACSM's Guidelines for Exercise Testing and Prescription, 7th Edition, 2005. Lippincott Williams and Wilkins http://www.lww.com) www.acsm-msse.org/pt/pt-core/template-journal/msse/media/0698c.htm

Client Initials _____

Additional Health History

Orthopedic (injury to/pain in):

____	Neck or Spine	____	Lower Back
____	Shoulders	____	Hips
____	Elbows	____	Knees
____	Wrists	____	Ankles
____	Fingers	____	Toes

Postural:

____	Scoliosis	Date: _____
____	Loridosis	Date: _____
____	Kryphosis	Date: _____

Notes: _____

_____

Other conditions:

____	Asthma	____	Recent Illness
____	Thyroid Disorder	____	Allergies
____	Hernia	____	Balance Problems
____	Anemia	____	Vision Problems (uncorrected)
____	Hypoglycemia	____	Hearing Problems
____	Seizures	____	Pregnancy
____	Ankle Edema	____	Surgeries (dates) _____

Notes: _____

_____

Date of Last Physical: _____

Physician's Name and Phone Number: _____

Emergency Contact:_____

_____ _____
Signature of Client Date

_____ _____
Signature of **APFITT** Specialist Date