

Pre – Screening Questionnaire

Section 1 Personal Particulars

Title _____ Name _____ Surname _____ DOB _____ Age _____
 Home _____ Mobile _____ Work _____
 Address _____
 _____ Postal Code _____
 Occupation _____ Email _____

In case of an emergency, whom should we contact for you?

Name _____ Relationship _____
 Work _____ Home _____

Section 2 Medical History

1. Have you consulted a doctor about starting an exercise program? (YES / NO)
2. Have you knowingly suffered from? (√ Tick if YES X If NO)

Heart condition		Pain or tightness in chest		Rheumatic Fever	
Arthritis		Heart Palpitations		Muscular Pain or Cramps	
Asthma		Any Infections or Infectious Diseases		Hernia	
Diabetes		Liver/ Kidney Condition		Back Pain	
Epilepsy		High/ Low Blood Pressure		Chronic Cough	
Regular headaches		Have you been hospitalized recently?		High Cholesterol	
Cancer		Female >45 yrs & unaccustomed to exercise?		Major Operations	
Thyroid Condition		Male >45 yrs & unaccustomed to exercise?		Any Major Injuries	
Are you pregnant?		Any condition that might limit your exercise?			

3. Do you regularly smoke? YES / NO

If you have TICKED or answered YES to any of the above, or have any other condition please give details:

4. Are you taking any non prescribed or prescribed medications? YES / NO. If yes, please provide details

5. Do you experience any side effects from these medications?

I have read and understand the above information and have completed this section to the best of my knowledge

Signature

Date