THE SPORTS CENTRE
PENISTONE GRAMMAR SCHOOL
FLYING TO A HEALTHIER LIFESTYLE

Instructor:

Health Screening Questionnaire

Personal Details			
Surname:		**Forename:**	
Date of Birth:	**Age:**	**Sex:** Male / Female	
Address:		**Contact Telephone:**	
	Post Code:	**Email:**	

Health Screening (please circle as appropriate)		
1. Has a Doctor or Medical Professional ever said you have a heart condition?	Yes	No
2. Do you have a family history of heart disease, stroke or diabetes?	Yes	No
3. Do you feel pain in your chest when you do physical activity?	Yes	No
4. In the past month have you had chest pain when you were not doing physical activity?	Yes	No
5. Have you recently had your blood pressure, cholesterol or blood sugar levels tested?	Yes	No
6. Do you ever suffer from dizziness, vertigo, balance problems or loss of consciousness?	Yes	No
7. Are you pregnant or have you given birth in the last 12 months?	Yes	No
8. Are you aged over 65 and unaccustomed to regular exercise?	Yes	No
9. Do you suffer from or have you ever suffered from:		

• Asthma / Breathlessness / Wheezing	Yes	No	• High Cholesterol	Yes	No
• Bronchitis	Yes	No	• High Blood Pressure	Yes	No
• Cystic Fibrosis	Yes	No	• Cardiovascular Disease (CHD / PVD)	Yes	No
• Chronic Obstructive Pulmonary Disease	Yes	No	• Heart Palpitations / Murmurs	Yes	No
• Joint / Muscle aches, pains, or injuries	Yes	No	• Heart Attack / Stroke / Angina	Yes	No
• Arthritis (Osteo / Rheumatoid)	Yes	No	• Varicose Veins	Yes	No
• Osteoporosis / Osteopenia	Yes	No	• Diabetes Mellitus (Type 1 or Type 2)	Yes	No
• Chronic Fatigue Syndrome / ME	Yes	No	• Haemophilia	Yes	No
• Sciatica / Nerve Problems	Yes	No	• Cancer	Yes	No
• Epilepsy / Fits	Yes	No	• Hearing / Visual Impairments	Yes	No
• Parkinson's Disease	Yes	No	• Anxiety / Depression	Yes	No
• Multiple Sclerosis	Yes	No	• Other……………………………………………………………		

10. Are you on any medication (including non-prescription medicines)? *please provide further details below.	Yes	No

Name of Medication	*Dose*	*Time of Day Taken*	*Side Effects Experienced*

Please use this space to provide any additional information relating to the questions above:

Physiological Tests							
• Blood Pressure (mmHg)				• Body Fat (%)			
• Resting Heart Rate (bts/min)				• Visceral Fat Rating			
• Waist / Hip Ratio				• Body Water (%)			
• Height / Weight / BMI				• Resting Metabolic Rate (Kcal)			

Lifestyle Questionnaire

Physical Activity / Lifestyle Analysis **(please circle as appropriate)**			
1. Are you employed?	Yes	No	Full time / part time / shift worker Hours…………..
2. If yes, what is your occupation?	……………………. Active Scale: (sedentary) 1 / 2 / 3 / 4 / 5 (Highly Active)		
3. Do you feel physically fit at the moment?	Yes	No	Unfit / below average / average / above average / fit
4. Do you partake in regular physical activity?	Yes	No	No. p/wk 1-2 / 3-4 / 5+ Duration 15-30 / 30-60 / 60+
5. Are these of low / moderate / high intensity?	Activities…………………………………………...……………………		
6. Are there 'barriers' to you becoming more active?	Yes	No	Barriers………………………………………………...
7. Would you like to increase your activity levels?	Yes	No	Reason………………………………………………..
8. Do you believe that being active is good for you?	Yes	No	Rationale………………………………………………
9. Are you comfortable with a gym environment?	Yes	No	Preferences: gym / studio / outdoor / sports / any
10. Do you smoke?	Yes	No	No. p/day…........................... Yrs……………………..
11. Have you previously smoked?	Yes	No	Stop date…......... No. p/day………. Yrs…………..
12. Do you drink alcohol?	Yes	No	Units p/wk……………….(1 unit = ½ pint beer; 1 glass of wine)

All information in this document will be treated in confidence and will only be made available to the exercise professional who supervises your programme. Please note that if there are any concerns as to your health status you may be required to obtain medical clearance before using our gym. Upon signing this form I agree at follow the Sports Centre rules as displayed on the fitness suite, and that all the information I have provided above is correct to the best of my knowledge and I will notify a member of gym staff with any changes in my health / medical status.

Client Signature:	**Date:**