Pre – Screening Questionnaire

Section 1 Personal Particulars

Title _____ Name _____Surname _____ Birth Date _____ Age _____

Home (____) _____ Mobile _____ Work (____) _____

Address _____ Suburb _____ PC _____

Occupation _____

Email _____

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

Name _____ Relationship _____ Home (___) _____

Work (____) _____

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 ✖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 Hospitalised Lately?		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 may limit your activity?			

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