Human Performance Lab Health Screening Form

Date_____

Technician Use Only
Height_____
Weight _____

Name_____ Age_____ Date of Birth _____ Major _____

Sex _____ Address _____ Phone _____ Occupation _____

Please answer the following questions honestly. Your responses will determine whether you may participate in either an exercise test or training program. All information is strictly confidential.

Current Physical Activity Patterns

1. Do your regularly sit for a large part of the day? No Yes

2. Please describe below everything you currently do for physical activity and/or exercise?

Activity/Exercise	Min/session	Days/wk	Intensity (circle one)	How long? (circle one)
			Light Moderate Vigorous	< 3 months > 3 months
			Light Moderate Vigorous	< 3 months > 3 months
			Light Moderate Vigorous	< 3 months > 3 months
			Light Moderate Vigorous	< 3 months > 3 months
			Light Moderate Vigorous	< 3 months > 3 months
			Light Moderate Vigorous	< 3 months > 3 months

Known Diseases (Medical Conditions)

3. List the medications you take on a regular basis. (Include vitamins & minerals, prescription and non-prescription)

   _____

   _____

4. Do you have diabetes? No Yes
   a. If yes, please indicate if it is Type 1 or Type 2. Type 1 Type 2
5. Have you had a stroke? No Yes
6. Have you ever had a heart attack or heart trouble? No Yes
7. Do you take asthma medication? No Yes
8. Do you have (or within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? No Yes
9. Is there any other physical reason that prevents you from participating in an exercise program (e.g. cancer, osteoporosis, severe arthritis, mental illness, thyroid, kidney or liver disease)? No Yes
10. Have you ever been diagnosed with another chronic medical condition or are you currently being treated for any other medical condition? No Yes

Signs and Symptoms of Disease **(use spaces between questions to explain your answers)**

11. Have you ever experienced pain in your heart, chest, neck, jaw, arms or other areas, especially during exercise? No Yes
12. Do you often feel faint or have spells of severe dizziness during exercise? No Yes
13. Do you experience unusual fatigue or shortness of breath at rest or with mild exertion? No Yes
14. Have you had an attack of shortness of breath that came on after you stopped exercising? No Yes
15. Have you been awakened at night by an attack of shortness of breath? No Yes
16. Do you experience swelling or accumulation of fluid in or around your ankles? No Yes
17. Do you often get the feeling that your heart is beating faster, racing, or skipping beats, either at rest or during exercise? No Yes
18. Do you regularly get pains in you calves or lower legs during exercise which are not due to soreness or stiffness? No Yes
19. Has your doctor ever told you that you have a heart murmur? No Yes

Cardiac Risk Factors

20. Do you or did you smoke cigarettes on a daily basis? No Yes
    a. If you did smoke when did you quit? (mm/dd/yy) _____
21. Has your doctor ever told you that you have high blood pressure? No Yes
22. Has a first degree relative (e.g. father, mother, sister, brother, or child) suffered from a heart attack or diagnosed cardiovascular disease? No Yes

Relative	Age	Did they pass away

23. What is your systolic blood pressure? _____ mmHg
24. What is your diastolic blood pressure? _____ mmHg
25. What is your total serum cholesterol level? _____ mmol/L or mg/dL
26. What is your serum HDL level? _____ mmol/L or mg/dL
27. What is your serum LDL level? _____ mmol/L or mg/dL
28. What is your fasting blood glucose level? _____ mmol/L or mg/dL
29. Has this been confirmed on two separate occasions? No Yes