





Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

**Please circle surgeries you have had & indicate year:**

Back Heart Kidney Ears Eyes Hernia Lung Eyes  
Joint Neck Other: \_\_\_\_\_

**Please circle any of the following for which you have been diagnosed or treated by a health professional or physician:**

Alcoholism	Concussion	Fibromyalgia	Hyperlipidemia	Osteoporosis
Asthma	Congenital Defect	Gout	Hypoglycemia	Pregnancy
Anemia	Coronary Disease	Hearing Loss	Incontinence	Phlebitis
Back Strain	Degenerative Arthritis	Heart Attack	Infectious Mononucleosis	Rheumatoid Arthritis
Bleeding Trait	Diabetes I	Hepatitis A	Kidney Problems	Stroke
Bronchitis, chronic	Diabetes II	Hepatitis B	Lupus	Thyroid Problem
Cholesterol	Emphysema	Hepatitis C	Multiple Sclerosis	Tuberculosis
Chronic joint pain	Epilepsy	HIV	Neck Strain	Ulcer
Cirrhosis liver	Eye Problems	High Blood Pressure	Obesity	Mental Illness

**Circle all medicine taken in the last 6 months:**

Blood Thinner <i>MC</i>	Epilepsy Medication	Diuretic	Heart Rhythm Medication
Nitroglycerin <i>MC</i>	Diabetic <i>MC</i>	Insulin <i>MC</i>	High Blood Pressure <i>MC</i>
Other _____			

**Use the key to indicate how often you have each of the following symptoms:**

5 = VERY OFTEN 4 = FAIRLY OFTEN 3 = SOMETIMES 2 = INFREQUENTLY 1 = PRACTICALLY NEVER N/A = NEVER

<b>Cough up blood</b> N/A 1 2 3 4 5	<b>Chest Pain</b> N/A 1 2 3 4 5	<b>Abdominal Pain</b> N/A 1 2 3 4 5	<b>Swollen Joints</b> N/A 1 2 3 4 5	<b>Low Back Pain</b> N/A 1 2 3 4 5
<b>Feel Faint</b> N/A 1 2 3 4 5	<b>Leg Pain</b> N/A 1 2 3 4 5	<b>Dizziness</b> N/A 1 2 3 4 5	<b>Arm/Shoulder Pain</b> N/A 1 2 3 4 5	<b>Breathless w/slight exertion</b> N/A 1 2 3 4 5

**PAR-Q :** If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

CHECK YES OR NO: Please answer honestly

- \_\_\_ 1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
- \_\_\_ 2. Do you feel pain in your chest when you do physical activity?
- \_\_\_ 3. In the past month, have you had chest pain when you were not doing physical activity?
- \_\_\_ 4. Do you lose your balance because of dizziness or do you ever lose consciousness?
- \_\_\_ 5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
- \_\_\_ 6. Is your doctor currently prescribing drugs (i.e. water pills) for your blood pressure or heart condition?
- \_\_\_ 7. Do you know of any other reason why you should not do physical activity?

**If YES to one or more questions--**Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

• You may be able to do any activity you want- as long as you start slowly and build up gradually. Or you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.

**NO to all questions:** If you answered NO to all PAR-Q questions, you can be reasonably sure that you can: start becoming much more physically active or take part in a fitness appraisal

**DELAY BECOMING MUCH MORE ACTIVE:** If you are not feeling well because of a temporary illness such as a cold or a fever; or if you are or may be pregnant- talk to you doctor before you start becoming more active.

I, (your name), testify that this medical history is accurate and true.

Signature \_\_\_\_\_ Date \_\_\_\_\_