

Lifestyle Questionnaire

Name: _____ DOB: _____ Sex: F/M

Address: _____

Phone: _____ Email: _____

Emergency contact person: _____ Relationship: _____

Emergency contact phone: _____

Have you ever had or do you have?Anyone in your family under 60 who has suffered Heart Disease, Stroke or Raised Cholesterol? Are you male over 45 or female over 55 and NOT used to regular vigorous exercise? Are you on prescription medication? Have you been hospitalised recently? Have you given birth in the last six weeks? Are you pregnant?

Do you have or have you had:

Arthritis Glandular Fever Diabetes Asthma Heart Murmur Epilepsy Stroke High Blood Pressure > 140/90 Hernia Dizziness or Fainting Palpitations or Pain in Chest Rheumatic Fever Stomach or Duodenal Ulcer Raised Cholesterol/Triglycerides Liver or Kidney Condition Any heart condition

If you ticked any of the above, please take this form to your doctor and ask for a clearance to exercise before starting any exercise program, OR sign below if you have already cleared the above condition with your doctor.

Please give details of condition and related medications on:

Signature: _____ Date cleared: _____

