Exercise Risk Assessment Form

Exercise Class

Name ____________________________________________     Gender ________     Age _______

Department / Unit ______________________________________________________________

Campus Address ______________________________________________________________

E-mail Address ______________________________________________________________

Campus Phone ______________________________________________________________

Please provide the following information as accurately and completely as possible so that we may assess whether you are a "suitable candidate" to begin an exercise program, or to complete a graded exercise test, body composition test, or other fitness test.

Known Cardiovascular, Pulmonary or Metabolic Disease

Have you been diagnosed with any of the following diseases/disorders/conditions or had any of the following procedures?

□ Yes □ No Myocardial infarction ("heart attack") 1 _________________________________

□ Yes □ No Stroke or ischemic attack ("mini-stroke") 2 _______________________________

□ Yes □ No Heart bypass surgery or other heart surgery 3 _____________________________

□ Yes □ No Coronary catheterization and/or angioplasty 4 _____________________________

□ Yes □ No Abnormal ECG (tachycardias, heart blocks, etc.) 5 _________________________

□ Yes □ No Other cardiovascular disease/disorder (aneurysm, etc.) 6 ______________________

□ Yes □ No Asthma or chronic pulmonary disease (COPD, etc.) 7 _________________________

□ Yes □ No Diabetes (insulin dependent, non-insulin dependent, etc.) 8 ______________________

□ Yes □ No Hyperlipidemia (high LDL, low HDL, etc.) 9 ______________________________

Comment: _______________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Signs or Symptoms Suggestive of Cardiovascular and Pulmonary Disease

Have you experienced any of the following?

□ Yes □ No Pain/discomfort in your chest, jaw or arms 10 ________________________________

□ Yes □ No Shortness of breath at rest or mild exertion 11 ______________________________

□ Yes □ No Dizziness or fainting spells 12 _____________________________________________

□ Yes □ No Difficulty breathing while lying down 13 _________________________________

□ Yes □ No Swelling of your ankles 14 _______________________________________________

□ Yes □ No "Skipped" heart beats or a "racing" heart beat 15 _____________________________

□ Yes □ No Occasional leg pain, especially while walking 16 ___________________________

□ Yes □ No Heart murmur 17 ______________________________________________________

□ Yes □ No Fatigue or shortness of breath with usual activities 18 _______________________

Comment: _______________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Risk Factors of Cardiovascular Disease
Do you have a personal history of any of the following?

☐ Yes  ☐ No  Cigarette smoking  19  Packs/day _____, yrs smoked _______

☐ Yes  ☐ No  Obesity or highly overweight  20  ________________________________

☐ Yes  ☐ No  Physical inactivity  21  ___________________________________________

☐ Yes  ☐ No  High blood pressure (over 140/90 mmHg)  22  Blood pressure _______

☐ Yes  ☐ No  High cholesterol (over 200 mg/dl)  23  Cholesterol ____________

☐ Yes  ☐ No  Diabetes or high blood sugar (over 110 mg/dl)  24  Blood glucose ____________

☐ Yes  ☐ No  Family history of heart attack/stroke, at young age  25  __________________________

Comment:  ____________________________________________________________

What is your current level of physical activity and exercise?  (Frequency, duration, types of activity, etc.)

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Physical Activity Readiness Questionnaire (PAR-Q)

☐ Yes  ☐ No  Has your doctor ever said you have a heart condition and should only do physical activity recommended by a doctor?  26

☐ Yes  ☐ No  Do you feel pain in your chest when you do physical activity?  27

☐ Yes  ☐ No  In the past month, have you had chest pain when you were not physically active?  28

☐ Yes  ☐ No  Do you lose your balance because of dizziness or do you ever lose consciousness?  29

☐ Yes  ☐ No  Do you have a bone or joint problem that could be made worse by a change in your physical activity?  30

☐ Yes  ☐ No  Is your doctor currently prescribing drugs for your blood pressure or heart condition?  31

☐ Yes  ☐ No  Do you know of any other reason why you should not do physical activity?  32

Comment:  ____________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Other Information Concerning Personal Health History
Do you have a personal history of any of the following?

Orthopedic diseases, disorders and/or conditions:

☐ Yes  ☐ No  Arthritis (osteo or rheumatoid)  33  ______________________________________

☐ Yes  ☐ No  Joint pain or joint swelling  34  ________________________________________

☐ Yes  ☐ No  Joint surgery  35  ____________________________________________________

☐ Yes  ☐ No  Joint replacement  36  ________________________________________________

☐ Yes  ☐ No  Low back pain  37  __________________________________________________

☐ Yes  ☐ No  Osteoporosis ("low bone density")  38  __________________________________

Comment:  ____________________________________________________________

_________________________________________________________________________________

 Neuromuscular diseases, disorders and/or conditions:

☐ Yes  ☐ No  Temporary loss of vision or speech  39  _______________________________

☐ Yes  ☐ No  Occasional significant numbness/weakness  40  ________________________

☐ Yes  ☐ No  Chronic fatigue  41  ______________________________________________

☐ Yes  ☐ No  Parkinson’s disease  42  ___________________________________________

☐ Yes  ☐ No  Multiple sclerosis  43  _____________________________________________

☐ Yes  ☐ No  Spinal cord injury  44  ______________________________________________

Comment:  ____________________________________________________________

_________________________________________________________________________________
Balance and/or mobility diseases, disorders and/or conditions:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Balance or gait problems 45</th>
<th>______________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Mobility problems 46</td>
<td>______________________________________________</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>History of falling 47</td>
<td>______________________________________________</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Inner ear/cerebellar problems 48</td>
<td>______________________________</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Visual/depth perception problems 49</td>
<td>______________________________</td>
</tr>
</tbody>
</table>

Comment: ____________________________________________________________

Immunological / hematological diseases, disorders and/or conditions:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Cancer 50</th>
<th>______________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Anemia 51</td>
<td>______________________________________________</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Immune disorders 52</td>
<td>______________________________</td>
</tr>
</tbody>
</table>

Comment: ____________________________________________________________

Female specific conditions:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Pregnant (currently) 53</th>
<th>______________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Amenorrhea (infrequent menstruation) 54</td>
<td>______________________________</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Menopause 55</td>
<td>______________________________________________</td>
</tr>
</tbody>
</table>

Comment: ____________________________________________________________

Drugs/Medications

Please list any prescription or over the counter (OTC) drugs/medications you are currently taking.

<table>
<thead>
<tr>
<th>Drug/Medication</th>
<th>Purpose/Reason for Taking</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________________________</td>
<td>__________________________</td>
</tr>
<tr>
<td>__________________________</td>
<td>__________________________</td>
</tr>
<tr>
<td>__________________________</td>
<td>__________________________</td>
</tr>
<tr>
<td>__________________________</td>
<td>__________________________</td>
</tr>
<tr>
<td>__________________________</td>
<td>__________________________</td>
</tr>
<tr>
<td>__________________________</td>
<td>__________________________</td>
</tr>
<tr>
<td>__________________________</td>
<td>__________________________</td>
</tr>
</tbody>
</table>

Doctor / Health Plan Information (Must be completed)

Name / Group ___________________________________________________________

Phone / Fax ___________________________________________________________

Address ______________________________________________________________

In Case of Emergency (Must be completed)

Name ________________________________________________________________

Phone ________________________________________________________________
Note to Employee Wellness Program Applicant

This health history information will be used to determine your “risk category” (as established by the American College of Sports Medicine) for participation in any exercise program or exercise assessment associated with the CSF Employee Wellness Program. This information will be kept confidential to the extent provided by law and will be released to no other party other than your personal physician or primary care provider without your written consent.

Depending on your “risk category” you may be asked to provide further Medical Clearance prior to specific exercise classes or fitness assessments or you may be excluded from participating in specific exercise classes or fitness assessments. If you are excluded from any specific exercise classes or fitness assessments, you will be referred to an appropriate facility for services.

Upon completion of this form, I declare and understand the following:

Initial

________ I have completed this health history to the best of my recollection and have not knowingly withheld any information concerning my health history.

________ I understand that this information will be used to assess my “risk category” for my participation in an exercise program and/or exercise assessment.

________ I understand that I may be excluded from any exercise program and/or exercise assessment based on my exercise risk or that my participation may in some way be restricted or altered.

_______________________________________  __________________
Signature         Date

Please return this form when completed and signed to:

Employee Wellness Program
KHS-121