



Health Screening Form

Personal Information

Name _____ Date: / /

Date of birth _____ Address _____

Phone (home) _____ (work) _____

Email address _____ (mobile) _____

Emergency contact

Name / Relationship _____ Phone _____

Doctor Name: _____ Doctor Contact no, _____

Physical activity should not pose any problem or hazard to the majority of people. The following questions are designed to identify the small number of adults for whom physical activity might be inappropriate or those who should seek medical advice prior to initiating a fitness program or other change in their physical activity levels.

Medical and Health Question

Please tick one

Yes / No

1. Are you accustomed to regular exercise? i.e. three times a week, _____/_____
2. Have you ever been diagnosed diabetes, asthma or epilepsy? _____/_____

If answered yes please provide details

3. Have you had any surgery in the last 3 months _____/_____

If answered yes please provide details below

4. Have you been hospitalized in the last 6 months? _____/_____

If answered yes, please give details below

5. Have you ever experience any difficulty breathing? _____/_____

If answered yes, describe under what conditions below,

6. Have you ever experienced pains in your heart? i.e. Irregular heartbeat. _____/_____

If answered yes please provide details below,

7. Have you ever been diagnosed with high blood pressure? _____/_____

If yes, please provide details below,

8. Have you ever smoked? If yes, please give details below, _____/_____

9. Do you know your cholesterol levels? If so, please state below, _____/_____

10. Have you received regular annual exams from your physician? _____/_____

If yes please give details of the Date of your last exam:

11. Are there any other conditions that your trainer should be aware of? _____/_____

Answered yes please give details below,

12. Please list any prescription medications or over-the-counter medications or supplements

You currently take _____

13. Have you been pregnant in the last 3 months? If yes please provide details below, ____/____

Declaration

I, _____, certify that I understand the foregoing questions and my answers are true and complete. I also understand that if this information changes in any way in the future, it is my responsibility to notify my trainer, and that I assume the risk for any changes in my medical condition that might affect my ability to exercise.

Before beginning a new fitness program or other significant change in your physical activity levels, you are advised to consult with your physician or primary health care provider. Only a physician or qualified health care provider is able to diagnose and prescribe treatment for specific health conditions.

I hereby assume full responsibility for any and all injuries, losses and damages that I incur while attending, exercising or participating in Mitchelstown Leisure Centre Gym. I hereby waive all claims against Mitchelstown Leisure Centre Gym, its instructors, or partners of individually or otherwise, for any and all injuries, claims or damages that I might incur.

I acknowledge that I have read the foregoing statements and fully understand the content thereof, and that if I choose not to consult with my physician or primary health care provider, I do so at my own risk.

Signature Date

Please print name

Parent or legal guardian (if participant is under age eighteen) Date