

HEALTH SCREENING FORM

Name _____ Date _____
 Sex _____ Age _____ Employee ID # _____ Dept Phone _____

What is the present state of your general health? _____

Physician's Name _____ Phone _____

Emergency Contact _____ Phone _____

What medications are you presently taking? _____

Are you now or have you been pregnant within the past three months? _____

Has your physician restricted your participation in exercise? _____

If yes, please describe _____

Do you have now or have you ever had:	<u>Yes</u>	<u>No</u>
1. A history of heart problems? _____	_____	_____
2. A history of lung disease? _____	_____	_____
3. Chest, neck, and/or jaw pains/discomforts at rest or during exertion? _____	_____	_____
4. Difficulty with physical exercise, such as chest pain/discomfort, dizziness or extreme shortness of breath? _____	_____	_____
5. Muscle, joint, or back disorder that could be aggravated by physical activity? If yes, please describe _____	_____	_____
6. A chronic illness? If yes, please list _____	_____	_____
7. High blood pressure? _____	_____	_____
8. Diabetes? _____	_____	_____
9. Cigarette-smoking habit? _____	_____	_____
10. High blood cholesterol? _____	_____	_____
11. History of heart problems in a 1 st degree relative (parents, siblings, children)? If yes, at what age? Mother _____ Father _____ Brother _____ Sister _____ Son _____ Daughter _____	_____	_____
12. Would you describe your lifestyle as sedentary (No regular exercise or active recreational pursuits)? If no, please describe your exercise program _____	_____	_____
13. Are you a male over age 45 or a female over age 55? _____	_____	_____

To the best of my knowledge, the above information is accurate and complete.

Signature _____ Date _____