



Health Risk Questionnaire

Please answer "yes" or "no" to the following questions. All information will be kept confidential and will not be released without prior written consent.

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Health:
<input type="checkbox"/>	<input type="checkbox"/>	1. Has your doctor ever said that you have a heart condition <u>and</u> that you should only do physical activity recommended by a doctor?
<input type="checkbox"/>	<input type="checkbox"/>	2. Is your doctor currently prescribing medication (for example, water pills) for your blood pressure or heart condition?
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis:
<input type="checkbox"/>	<input type="checkbox"/>	3. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	4. Do you have arthritis or fibromyalgia? (Or daily joint pain/ stiffness) <input type="checkbox"/> If yes, have you been diagnosed and/ or on medication for it?
<input type="checkbox"/>	<input type="checkbox"/>	5. Have you ever had a joint injury or replacement?
<input type="checkbox"/>	<input type="checkbox"/>	Oncology:
<input type="checkbox"/>	<input type="checkbox"/>	6. Have you been diagnosed with Cancer?
<input type="checkbox"/>	<input type="checkbox"/>	7. Are you currently undergoing treatment?
<input type="checkbox"/>	<input type="checkbox"/>	Other Health:
<input type="checkbox"/>	<input type="checkbox"/>	8. Do you feel pain in your chest when you do physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	9. In the past month, have you had chest pain when you were not doing physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	10. Do you lose your balance because of dizziness or do you ever lose consciousness?
<input type="checkbox"/>	<input type="checkbox"/>	11. Do you know of <u>any other reason</u> why you should not do physical activity?

Primary Care Physician: _____

If you have answered "yes" to any questions on the Health Risk Questionnaire, Beacon Health & Fitness recommends that you consult your physician before participating in the Fitness Assessment and overall physical activity.

Note: If this form is being given to a person before he/she participates in a physical activity program or a fitness appraisal, the section may be used for legal or administrative purposes.

If any response on the Health Risk Questionnaire changes during membership, it is your responsibility to inform a fitness specialist prior to continuing physical activity at Beacon Health & Fitness.

I have read, understood, and completed this questionnaire. Any questions I had were answered to my full satisfaction.

Name: _____ Date: _____

Signature: _____
Signature of Parent or Guardian (for participants under the age of majority)

Witness: _____ Time: _____