Pre Exercise Questionnaire

Name: ..... D.O.B ..... /..... /.....

Male / Female

Address:.....

.....

Phone number: .....

Emergency contact:.....Phone: .....

Email Address: .....

Do you currently have, or previously had any of the following conditions or symptoms?

Heart/ cardiac condition	Y	N	Chest pain	Y	N
Asthma/lung condition	Y	N	Dizzy/ fainting spells	Y	N
Arthritis/bone/ joint condition	Y	N	Type II Diabetes	Y	N
Type I Diabetes	Y	N	Hypertension	Y	N
Allergies – food, seasonal, bees	Y	N	Hypotension	Y	N
Nervous system condition	Y	N	Epilepsy	Y	N
Vision difficulties	Y	N	Hearing Difficulties	Y	N

If you answered Yes to any of the above, please explain:

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Are you currently taking any medication or are you under the care of a Doctor or specialist?

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Have you had any injuries or surgery? Please provide details:

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I confirm that all of the above information is true.

Signature: ..... Date:...../...../.....