

**The University of Texas
Fitness Institute of Texas
Health and Fitness Screening Questionnaire**

ID _____

Please answer the following questions to the best of your knowledge by checking yes, no or unknown.

Section 1:	Yes	No	Unknown
1. Has a doctor ever said that you have a heart condition and recommended only medically supervised physical activity?	_____	_____	_____
2. Do you have chest pain brought on by physical activity?	_____	_____	_____
3. Have you developed chest pain in the last month when not doing physical activity?	_____	_____	_____
4. Do you lose your balance because of dizziness or do you ever lose consciousness?	_____	_____	_____
5. Has a doctor ever recommended medication for your blood pressure or a heart condition?	_____	_____	_____
6. Are you aware through your own experience, a doctor's advice, or any other physical reason that would prohibit you from engaging in physical activity?	_____	_____	_____
Section 2:			
7. Do you smoke or have you quit within the last six months?	_____	_____	_____
8. Is your blood cholesterol level >240 mg/dl?	_____	_____	_____
9. Do you have a close relative who has had a heart attack or sudden death before age 55 (father or brother) or age 65 (mother or sister)?	_____	_____	_____
10. Are you physically inactive (less than 30 minutes of physical activity 3 days per week)?	_____	_____	_____
Section 3:			
11. Have you ever experienced pain or discomfort in the chest, neck, jaw, arm, or other areas of your body that indicate lack of blood flow to the heart?	_____	_____	_____
12. Do you ever experience shortness of breath at rest or with mild physical activity?	_____	_____	_____
13. Do you ever experience shortness of breath while lying flat or wake up in the middle of the night with shortness of breath?	_____	_____	_____
14. Do you currently have swelling of your ankles?	_____	_____	_____
15. Do you ever experience palpitations of your heart or a very rapid heart rate with mild exertion?	_____	_____	_____
16. Do you ever experience unusual fatigue or shortness of breath with usual daily activities?	_____	_____	_____
17. Do you ever experience pain in your legs while exercising that is relieved by rest?	_____	_____	_____
Section 4:			
18. Do you have a bone or joint problem that could be aggravated by engaging in physical fitness testing?	_____	_____	_____
19. Are you currently experiencing or have you recently experienced any muscle or joint pain?	_____	_____	_____

	Yes	No	Unknown
20. Do you now have or have you ever had asthma?	_____	_____	_____
21. Do you now have or have you ever had:			
a. Coronary heart disease, heart attack, coronary artery surgery	_____	_____	_____
b. Angina	_____	_____	_____
c. High blood pressure	_____	_____	_____
d. Peripheral vascular disease	_____	_____	_____
e. Stroke	_____	_____	_____
f. Diabetes	_____	_____	_____
g. Thyroid problems	_____	_____	_____
h. Hepatitis	_____	_____	_____
i. Arthritis	_____	_____	_____
j. Gout	_____	_____	_____
k. Headaches that are chronic and severe	_____	_____	_____
l. Head injury or epilepsy	_____	_____	_____
m. Abdominal pain, hernia, or G.I. bleeding	_____	_____	_____
n. Kidney problems or discomfort when urinating	_____	_____	_____
o. Tendency to bleed or bruise easily	_____	_____	_____
p. Anemia	_____	_____	_____
q. Lung problems	_____	_____	_____
r. Liver problems	_____	_____	_____
22. Have you been diagnosed by your doctor as having a heart murmur?	_____	_____	_____
23. Have you donated blood or lost an equivalent amount of blood from injury within the past 2 weeks?	_____	_____	_____
24. Are you now or have you been pregnant in the last month?	_____	_____	_____
25. Have you recently been ill or injured?	_____	_____	_____
If yes, please describe: _____			
26. How satisfied are you with your current weight? (Circle one)			
Very satisfied Satisfied Dissatisfied Very Dissatisfied			
Please briefly explain: _____			
27. Are you currently taking any physician prescribed medications for the following conditions? If yes, list the medication.			
<u>Medication</u> <u>Name of Medication</u>			
-Heart medicine _____	_____	_____	_____
-Blood pressure medicine _____	_____	_____	_____
-Hormones _____	_____	_____	_____
-Medicine for breathing/lungs _____	_____	_____	_____
-Insulin _____	_____	_____	_____
-Other medicine for diabetes _____	_____	_____	_____
-Arthritis medicine _____	_____	_____	_____
-Medicine for depression _____	_____	_____	_____
-Medicine for anxiety _____	_____	_____	_____
-Thyroid medicine _____	_____	_____	_____
-Medicine for ulcers _____	_____	_____	_____
-Painkiller medicine _____	_____	_____	_____
-Allergy medicine _____	_____	_____	_____
-Other _____	_____	_____	_____
28. Are you currently taking any over the counter medications?	_____	_____	_____
Please list these medications: _____			
29. For females taking the DEXA test: Are you pregnant?	_____	_____	_____
30. Have you previously been tested at the Fitness Institute of Texas?	_____	_____	_____

Section 5:

Physical activity: Fill in this chart based on the activities you have participated in during the last 6 months from most frequent to least frequent. Also estimate the average number of times, duration, and intensity of each activity.

Type of Activity (i.e. running, cycling, swimming)	How long have you participated in the activity Years/Months	Avg. # of times per week	Avg. # of minutes each time	Intensity: How hard you work (refer to question below)

How hard would you describe the intensity of your exercise?

- a. extremely light
- b. very light

- c. somewhat hard
- d. hard

- e. very hard
- f. extremely hard

My primary fitness goals are: 1 _____

2. _____

3. _____