



Kentlands/Lakelands 5k GOT Fit (Feet in Training) Senior Walking Program



Medical Health Questionnaire

First Name: _____ **Last Name:** _____

	YES	NO
1. Have you had a physical from your physician within the past year?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has a physician ever advised you not to exercise?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been given an exercise prescription by a physician?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever or do you have difficulty with physical exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is there a history of heart problems with you or your immediate family?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have high blood pressure or high blood cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have diabetes? If so, do you take insulin? Yes No	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had a history of respiratory (breathing) or lung problems?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had a stroke (also called cerebrovascular accident)?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have a thyroid problem?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have a chronic illness or condition?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have a hernia, or any condition that may be aggravated by lifting weights?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you smoke? How many cigarettes/packs per day?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever had any surgeries? Please list dates & procedures below	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever had any muscle, joint, or back/neck injury (including but not limited to disc injury, fracture, sprain)?	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you have any muscle, joint, back injury or any previous injury still affecting you?	<input type="checkbox"/>	<input type="checkbox"/>
17. Are you currently taking any medication that directly affects the heart, lungs or circulatory system (i.e. beta blockers, cholesterol or blood pressure medication)?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever experienced dizzy spells?	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have a history of seizures?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above questions, please explain below. Use the back if necessary:

I understand this Medical Health Questionnaire serves as a preliminary screening resource to assist our professionals in the determination of member risk to exercise. If the information above indicates an increased risk for exercise, I authorize Elite Performance & Physical Therapy, Inc to contact my physician for approval and recommendations for my exercise program. If I am at risk and have not received medical clearance, I understand I cannot engage in any exercise tests or receive recommendations from any staff member. I will use the facilities aware of my risk and may seek only operational advice from the staff. I agree that Elite Performance & Physical Therapy, Inc. shall not be liable for any injuries or damages arising from the use of the club.

Signature: _____ **Date:** _____