



**HEALTH QUESTIONNAIRE:**

So we can work out a training programme that is suitable for you, please fill out the information below.

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1 - Has your doctor ever said you have heart trouble?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 - Have you ever had pains in your chest?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 - Do you often feel faint or have spells of dizziness?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 - Has a doctor said your blood pressure is too high?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 - Has your doctor said you may have bone or joint problems such as arthritis, that has been aggravated by exercise or may be made worse with exercise?.. | <input type="checkbox"/> | <input type="checkbox"/> |
| 6 - Have you been in hospital in the last 3 years?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7 - Are you currently taking any medication?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8 - If 'Yes' what medication do you take? .....  |                          |                          |
| 9 - Are you Pre/Post natal?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10 - Do you suffer from asthma, or breathing difficulties?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11 - Do you suffer from diabetes or epilepsy?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12 - Do you suffer from an allergy?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13 - If 'Yes,' what medication do you take? .....  |                          |                          |
| 14 - Is there any other physical reason why you should not follow an activity programme?.....  | <input type="checkbox"/> | <input type="checkbox"/> |

**If you have answered yes to one or more of these questions or are in any doubt, if you have not recently done so, consult your doctor before increasing your physical activity and tell your doctor which questions you answered yes to.**

**CONFIRMATION:**

Student Name: ..... Date: ..... / ..... / .....

Signature: .....