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 either yes or no.

Section 1:
1. Has a doctor ever said that you have a heart condition and recommended only medically supervised physical activity? Yes No Unknown
2. Do you have chest pain brought on by physical activity? Yes No Unknown
3. Have you developed chest pain in the last month when not doing physical activity? Yes No Unknown
4. Do you lose your balance because of dizziness or do you ever lose consciousness? Yes No Unknown
5. Has a doctor ever recommended medication for your blood pressure or a heart condition? Yes No Unknown
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? Yes No Unknown

Section 2:
7. Do you smoke or have you quit within the last six months? Yes No Unknown
8. Is your blood cholesterol level >240 mg/dl? Yes No Unknown
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)? Yes No Unknown
10. Are you diabetic or taking medicine to control blood sugar? Yes No Unknown
11. Are you physically inactive (less than 30 minutes of physical activity 3 days per week)? Yes No Unknown

Section 3:
12. 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? Yes No Unknown
13. Do you ever experience shortness of breath at rest or with mild physical activity? Yes No Unknown
14. Do you ever experience shortness of breath while lying flat or wake up in the middle of the night with shortness of breath? Yes No Unknown
15. Do you currently have swelling of your ankles? Yes No Unknown
16. Do you ever experience palpitations of your heart or a very rapid heart rate with mild exertion? Yes No Unknown
17. Do you ever experience unusual fatigue or shortness of breath with usual daily activities? Yes No Unknown
18. Do you ever experience pain in your legs while exercising that is relieved by rest? Yes No Unknown

Section 4:
19. Do you have a bone or joint problem that could be aggravated by engaging in physical fitness testing? Yes No Unknown
20. Are you currently experiencing or have you recently experienced any muscle or joint pain? Yes No Unknown
21. Do you now have or have you ever had asthma? Yes No Unknown
22. 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

23. Have you been diagnosed by your doctor as having a heart murmur?

24. Have you donated blood or lost an equivalent amount of blood from injury within the past 2 weeks?

25. Are you now or have you been pregnant in the last month?

26. Have you recently been ill or injured?
   If yes, please describe: __________________________________________________________

28. Are you currently taking any physician prescribed medications for the following conditions. If yes, list the medications.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Name of Medication</th>
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<tbody>
<tr>
<td>Heart medicine</td>
<td></td>
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<tr>
<td>Blood pressure medicine</td>
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<tr>
<td>Hormones</td>
<td></td>
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<tr>
<td>Medicine for breathing/lungs</td>
<td></td>
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<tr>
<td>Insulin</td>
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<tr>
<td>Other medicine for diabetes</td>
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<tr>
<td>Arthritis medicine</td>
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<tr>
<td>Medicine for depression</td>
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<td>Medicine for anxiety</td>
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<tr>
<td>Thyroid medicine</td>
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<td>Medicine for ulcers</td>
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<tr>
<td>Painkiller medicine</td>
<td></td>
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<tr>
<td>Allergy medicine</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

29. Are you currently taking any over the counter medications?
   Please list these medications: _________________________________________________________

30. For females taking the DEXA test:
   -- Are you premenopausal

   Have you previously been tested at the Fitness Institute of Texas?  _____  _____
Sec. 5

In order for the trainer to prescribe the most appropriate workout plan for you, please answer the following questions and provide any other fitness or health related details that you feel important to creating the exercise plan.

How satisfied are you with your current weight/body composition?
   a. Very satisfied
   b. Satisfied
   c. Somewhat satisfied/somewhat dissatisfied
   d. Dissatisfied
   e. Very dissatisfied

If you are not satisfied or very satisfied with your weight/body composition, what would make you satisfied?
   a. To gain weight and/or muscle
   b. To lose 5-10 lbs
   c. To lose 10-15 lbs
   d. To lose 15-25 lbs
   e. To lose 25 or more lbs

How many minutes of moderate to vigorous intensity aerobic exercise do you do each week? (walking fast, jogging, basketball, water aerobics, bike riding, swimming, tennis, etc)
   a. None
   b. 0.5-1 hour
   c. 1-1.5 hours
   d. 1.5-2.5 hours
   e. 2.5-3.5 hours
   f. >3.5 hours

How many minutes of resistance or weight training type exercises do you do each week?
   a. None
   b. 0.5-1 hour
   c. 1-1.5 hours
   d. 1.5-2.5 hours
   e. 2.5-3.5 hours
   f. >3.5 hours

How long have you been exercising regularly?
   a. I do not exercise
   b. Less than 3 months
   c. 3-6 months
   d. 6 months – 1 year
   e. 1-2 years
   f. 2-5 years
   g. >5 years

What is your primary fitness related goal?
   a. Lose weight/decrease body fat
   b. Gain muscle/strength
   c. Improve cardiovascular fitness
   d. Improve flexibility
   e. Be/stay healthy
   f. Esthetic reasons
g. Athletic performance  
h. I do not have a goal

Where will you be doing your workouts? Please circle more than one if applicable.
   a. Park/trail  
   b. Neighborhood  
   c. Gym  
   d. Home  
   e. Other: _________________________________

What kind of workout would you like prescribed? (For example: aerobic, circuit, a mixture of weights and aerobic, strictly weights for muscle building, HIIT)

How much time do you have for each of your workouts? How many days per week do you plan to workout? (i.e. 30 minutes per workout/5 days per week, 1 hour per workout/3 days per week)

What do your current workouts look like? What kind of exercises are you doing, for how long, and where are you doing these workouts?

Do you have any injuries or health conditions that prevent you from doing certain exercises?

Are there any movements or exercises that you avoid, are uncomfortable with, or that may cause pain?

What equipment will you have access to for your workouts? Please also include the weights that are available for each piece of equipment. (For example – dumbbells 6lbs & 10 lbs; medicine ball 12 lbs)
Do you have any exercises or pieces of equipment that are your favorites and that you love to include in your workouts?

Are there any pieces of equipment or exercise machines that you avoid or are uncomfortable for you to work with?

Is there any other information that you feel important for the trainer to consider when prescribing your workout plan?