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:	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 diabetic or taking medicine to control blood sugar?	____	____	____
11. Are you physically inactive (less than 30 minutes of physical activity 3 days per week)?	____	____	____
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?	____	____	____
13. Do you ever experience shortness of breath at rest or with mild physical activity?	____	____	____
14. Do you ever experience shortness of breath while lying flat or wake up in the middle of the night with shortness of breath?	____	____	____
15. Do you currently have swelling of your ankles?	____	____	____
16. Do you ever experience palpitations of your heart or a very rapid heart rate with mild exertion?	____	____	____
17. Do you ever experience unusual fatigue or shortness of breath with usual daily activities?	____	____	____
18. Do you ever experience pain in your legs while exercising that is relieved by rest?	____	____	____
Section 4:			
19. Do you have a bone or joint problem that could be aggravated by engaging in physical fitness testing?	____	____	____
20. Are you currently experiencing or have you recently experienced any muscle or joint pain?	____	____	____
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.

Medication	Name of Medication			
-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	____________________	____	____	____

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 be 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?