**HEALTH QUESTIONNAIRE**

**Subject ID Number……………………………………………….………**

**Please answer these questions truthfully and completely. The sole purpose of this questionnaire is to ensure that you are in a fit and healthy state to complete the exercise test.**

**ANY INFORMATION CONTAINED HEREIN WILL BE TREATED AS CONFIDENTIAL.**

**SECTION 1: GENERAL HEALTH QUESTIONS**

**Please read the 10 questions below carefully and answer each one honestly: check YES or NO.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | | **YES** | **NO** |
| 1. Has your doctor ever said that you have a heart condition or high blood pressure? | | □ | □ |
| 1. Do you feel pain in your chest at rest, during your daily activities of living, or when you do physical activity? | | □ | □ |
| 1. Do you lose balance because of dizziness or have you lost consciousness in the last 12 months? (Please answer NO if your dizziness was associated with over-breathing including vigorous exercise). | | □ | □ |
| 1. Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? | | □ | □ |
| If yes, please list condition(s) here: | | | |
| 1. Are you currently taking prescribed medications for a chronic medical condition? | | □ | □ |
| If yes, please list condition(s) and medications here: | | | |
| 1. Do you currently have (or have you had within the past 12 months) a bone, joint or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer NO if you had a problem in the past but it *does not limit your ability* to be physically active. | | □ | □ |
| If yes, please list condition(s) here: | | | |
| 1. Has your doctor ever said that you should only do medically supervised physical activity? | | □ | □ |
| 1. Are you, or is there any chance you could be, pregnant? | | □ | □ |
| 9. | Do you currently participate in intermittent exercise/sports on a weekly basis? | □ | □ |
| 10. | Please provide brief details of your current weekly levels of physical activity (sport, physical fitness or conditioning activities), using the following classification for exertion level:  L = light (slightly breathless)  M = moderate (breathless)  V = vigorous (very breathless)  Activity Duration (mins.) Level (L/M/V)  Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday | | |

**If you answered NO to all of the questions 1-8 above (but YES to question 9), you are cleared to take part in the exercise test**

**Please sign the relevant declaration on the consent form.**

**YOU DO NOT NEED TO COMPLETE SECTION 2.**

** If you answered YES to one or more of the questions in Section 1 - PLEASE GO TO SECTION 2.**

**SECTION 2: CHRONIC MEDICAL CONDITIONS**

**Please read the questions below carefully and answer each one honestly: check YES or NO.**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **YES** | **NO** |
| **1.** | **Do you have arthritis, osteoporosis, or back problems?**  If YES answer questions 1a-1c. If NO go to Question 2. | □ | □ |
| 1a. | Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking any medications or other treatments). | □ | □ |
| 1b. | Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebrae (e.g. spondylolisthesis), and/or spondyloysis/pars defect (a crack in the bony ring on the back of the spinal column)? | □ | □ |
| 1c. | Have you had steroid injections or taken steroid tablets regularly for more than 3 months? | □ | □ |
| **2.** | **Do you have cancer of any kind?**  If YES answer questions 2a-2b. If NO, go to Question 3. | □ | □ |
| 2a. | Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head and neck? | □ | □ |
| 2b. | Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)? | □ | □ |
| **3.** | **Do you have heart disease or cardiovascular disease? This includes coronary artery disease, high blood pressure, heart failure, diagnosed abnormality or heart rhythm.**  If YES answer questions 3a-3e. If NO go to Question 4. | □ | □ |
| 3a. | Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking any medications or other treatments). | □ | □ |
| 3b. | Do you have an irregular heartbeat that requires medical management?  (e.g. atrial fibrillation, premature ventricular contraction) | □ | □ |
| 3c. | Do you have chronic heart failure? | □ | □ |
| 3d. | Do you have a resting blood pressure equal to or greater than 160/90mmHg with or without medication? Answer YES if you do not know your resting blood pressure. | □ | □ |
| 3e. | Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months? | □ | □ |

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| --- | --- | --- | --- |
|  |  | **YES** | **NO** |
| **4.** | **Do you have any metabolic conditions? This includes Type 1 Diabetes, Type 2 Diabetes and Pre-Diabetes.** If YES answer questions 4a-4c. If NO, go to Question 5. | □ | □ |
| 4a. | Is your blood sugar often above 13mmol/L? (Answer YES if you are not sure). | □ | □ |
| 4b. | Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, OR the sensation in your toes and feet? | □ | □ |
| 4c. | Do you have other metabolic conditions (such as thyroid disorders, current pregnancy related diabetes, chronic kidney disease, or liver problems)? | □ | □ |
| **5.** | **Do you have any mental health problems or learning difficulties?** This includes Alzheimer’s, dementia, depression, anxiety disorder, eating disorder, psychotic disorder, intellectual disability and down syndrome.  If YES answer questions 5a-5b. If NO go to Question 6. | □ | □ |
| 5a. | Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking any medications or other treatments). | □ | □ |
| 5b. | Do you also have back problems affecting nerves or muscles? | □ | □ |
| **6.** | **Do you have a respiratory disease?** This includes chronic obstructive pulmonary disease, asthma, pulmonary high blood pressure.  If YES answer questions 6a-6d. If NO, go to Question 7. | □ | □ |
| 6a. | Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking any medications or other treatments). | □ | □ |
| 6b. | Has your doctor ever said you blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy? | □ | □ |
| 6c. | If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week? | □ | □ |
| 6d. | Has your doctor ever said you have high blood pressure in the blood vessels of your lungs? | □ | □ |
| **7.** | **Do you have a spinal cord injury?** This includes tetraplegia and paraplegia.  If YES answer questions 7a-7c. If NO, go to Question 8. | □ | □ |
| 7a. | Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking any medications or other treatments). | □ | □ |
| 7b. | Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting? | □ | □ |
| 7c. | Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as autonomic dysreflexia)? | □ | □ |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **YES** | **NO** |
| **8.** | **Have you had a stroke?** This includes transient ischemic attack (TIA) or cerebrovascular event.  If YES answer questions 8a-8c. If NO go to Question 9. | □ | □ |
| 8a. | Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking any medications or other treatments). | □ | □ |
| 8b. | Do you have any impairment in walking or mobility? | □ | □ |
| 8c. | Have you experienced a stroke or impairment in nerves or muscles in the past 6 months? | □ | □ |
| **9.** | **Do you have any other medical condition which is not listed above or do you have two or more medical conditions?**  If you have other medical conditions, answer questions 9a-9c. If NO go to Question 10. | □ | □ |
| 9a. | Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months OR have you had a diagnosed concussion within the last 12 months? | □ | □ |
| 9b. | Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, and kidney problems)? | □ | □ |
| 9c. | Do you currently live with two or more medical conditions? | □ | □ |
|  | Please list your medical condition(s) and any related medications here: | | |
| **10.** | **Have you had a viral infection in the last 2 weeks (cough, cold, sore throat, etc.)?** If YES please provide details below: | □ | □ |
| **11.** | **Is there any other reason why you cannot take part in this exercise test?** If YES please provide details below: | □ | □ |

**Please see below for recommendations for your current medical condition and sign this document:**

**If you answered NO to all of the follow-up questions about your medical condition, you are cleared to take part in the exercise test.**

**If you answered YES to one or more of the follow-up questions about your medical condition it is strongly advised that you should seek further advice from a medical professional before taking part in the exercise test.**

This health questionnaire is based around the PAR-Q+, which was developed by the Canadian Society for Exercise Physiology [www.csep.ca](http://www.csep.ca)