



WRC Staff Use Only. WRC Staff initials _____	
CVD Risk Classification? Low Moderate High	Database entry? Yes No.
Physician Clearance? Yes No	BC Assessment appointment: _____/_____/_____
Health/Medical History form signed? Yes No	
Assumption of Risk form signed? Yes No	Orientation complete? Yes No

HEALTH/MEDICAL QUESTIONNAIRE

Name (Please Print) _____ o Male o Female

Department _____ College or Unit _____

Phone (Home) (____) _____ (Work) (____) _____

DOB ____/____/____ Occupation (circle) A&P Faculty USPS Other

E-mail _____ Employee ID _____

Emergency Contact _____ Phone (____) _____

Login ID _____

Physical Activity Readiness Questionnaire (PAR-Q)

Yes No

- 1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?**
- 2. Do you feel pain in your chest when you do physical activity?**
- 3. In the past month, have you had chest pain when you were not doing physical activity?**
- 4. Do you lose your balance because of dizziness or lose consciousness?**
If yes, explain:
- 5. Do you have a bone or joint problem that could be made worse by physical activity?
- 6. Is your doctor presently prescribing drugs for your blood pressure or heart condition?
If yes, please specify:
- 7. Are you aware, through your own experience or a doctor's advice other physical reason that would prohibit you from exercising without medical supervision?

If you have answered yes to any of the above questions in bold please have your physician complete an approval form prior to working out.



Cardiovascular Risk Factors

- | Yes | No | |
|-----------------------|-----------------------|----------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="radio"/> | <input type="radio"/> | 8. Are you a man older than 45 years? |
| <input type="radio"/> | <input type="radio"/> | 9. Are you a women older than 55 years or have you had a hysterectomy or are you postmenopausal? |
| <input type="radio"/> | <input type="radio"/> | 10. Do you currently smoke?
If yes, how many per day? _____ How long? _____ |
| <input type="radio"/> | <input type="radio"/> | 11. Is your blood pressure greater than 140/90? |
| <input type="radio"/> | <input type="radio"/> | 12. Do you know your blood pressure? If yes, please specify:
_____ / _____ |
| <input type="radio"/> | <input type="radio"/> | 13. Have you ever been told that your total cholesterol is > 200 mg/dL, <u>or</u> your HDL is < 40 mg/dL, <u>or</u> your LDL is > 130 mg/dL? |
| <input type="radio"/> | <input type="radio"/> | 14. Do you know your blood cholesterol level?
If yes, please specify: Total _____, LDL _____, HDL _____ |
| <input type="radio"/> | <input type="radio"/> | Have you had a close blood relative who had a heart attack before age 55 (father or brother) or age 65 (mother or sister)? |
| <input type="radio"/> | <input type="radio"/> | 16. Are you a diabetic or do you take medication to control your blood sugar? |
| <input type="radio"/> | <input type="radio"/> | Are you physically inactive (i.e. you get less than 30 minutes of physical activity on at least 3 days per week)? |
| <input type="radio"/> | <input type="radio"/> | 17. Are you more than 20 pounds overweight?
Approximate Height _____ Weight _____
Body Mass Index (BMI) _____ |



Assessment of Health Needs

18. Please check any conditions or diseases you now have or have had in the past.

Date		Date	
	<input type="checkbox"/> Heart Attack		<input type="checkbox"/> Diabetes
	<input type="checkbox"/> Arrhythmia		<input type="checkbox"/> Thyroid Disease
	<input type="checkbox"/> Stroke		<input type="checkbox"/> Hepatitis
	<input type="checkbox"/> Coronary Bypass, Angioplasty, or other cardiac surgery		<input type="checkbox"/> Anemia
	<input type="checkbox"/> Peripheral Vascular Disease		<input type="checkbox"/> Amenorrhea
	<input type="checkbox"/> Valvular Heart Disease		<input type="checkbox"/> Bleeding Disorders
	<input type="checkbox"/> Congestive Heart Failure		<input type="checkbox"/> Chronic Fatigue Syndrome
	<input type="checkbox"/> Heart Murmur		<input type="checkbox"/> Diagnosed Bulimia or Anorexia Nervosa
	<input type="checkbox"/> Asthma		<input type="checkbox"/> Allergies
	<input type="checkbox"/> Renal Failure		<input type="checkbox"/> Ulcer or other Stomach/Intestinal Problem
	<input type="checkbox"/> Emphysema		<input type="checkbox"/> Hernia
	<input type="checkbox"/> Dyspnea		<input type="checkbox"/> Depression/Emotional Disorders
	<input type="checkbox"/> Phlebitis or Emboli		<input type="checkbox"/> Trouble Sleeping/Sleep Apnea (circle)
	<input type="checkbox"/> Ankle Edema		<input type="checkbox"/> Back/Shoulder/Neck Problems (circle)
	<input type="checkbox"/> Pneumonia		<input type="checkbox"/> Hip/Knee/Foot Problems (circle)
	<input type="checkbox"/> Unusual Shortness of Breath		<input type="checkbox"/> Arthritis/Tendonitis (circle)
	<input type="checkbox"/> Bronchitis		<input type="checkbox"/> Broken Bones (describe below)

If you checked any of the previous diseases or conditions, please provide details:

20. Please list any prescribed medications and dosages you are currently taking: (if you are not taking any please write None.)

Medicine	Dose	Reason	Medicine	Dose	Reason



21. Please list any over-the-counter medications or dietary supplements and doses you are currently taking: (if you are not taking any please write none)

Supplement/Medicine	Dose	Reason	Supplement/Medicine	Dose	Reason

22. Please list any hospitalization or surgical procedure within the last two years:

Hospitalization/Surgery	Date	Reason	Hospitalization/Surgery	Date	Reason

23. Are you currently pregnant or have you given birth within the last 6 months:

Yes No

24. Please select your fitness/wellness goals from the following:

- Improve Aerobic Fitness
 Improve Strength
 Gain Muscle
 Lose Fat
 Improve flexibility
 Other _____

25. Please provide us with any additional information to help us personalize your program.

Signature

Date



Assumption of Risk

The Faculty or Staff Member acknowledges that The Wellness Research Center has informed the Faculty/Staff of increased risk of musculoskeletal injury and cardiopulmonary incidences while exercising. Although exercise induced incidences are low, there remains an inherent risk. The Faculty/Staff acknowledges that the use of exercise at the Center's facilities involves risk of personal injury, including heart attack, and other coronary complications. With this knowledge, the Faculty/Staff assumes all responsibility for all risk of injury that may occur to Faculty/Staff while present in the Center.

In consideration of being accepted as a participant of the center, the Faculty/Staff agrees to release and hold harmless The University of Central Florida and their agents, servants, and employees from all claims, liability, demands, rights, and causes of action, present or future, whether known, anticipated, or unanticipated, resulting from or arising out of, or incident to Member's use of, presence at, or membership in the Center.

Signature: _____

Date: _____

Print Name: _____

Witness: _____

Date: _____