

New Jersey Sports Medicine and Performance Center
689 Valley Road · Suite 104 · Gillette · NJ · 07933
(908) 647 - 6464

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

MEDICATIONS: _____

ALLERGIES: _____

- | | <u>YES</u> | <u>NO</u> |
|--|--------------------------|--------------------------|
| 1. Has a doctor ever said you have a heart condition and recommended only medically supervised physical activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have chest pain brought on by physical activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you developed chest pain within the past month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you tend to lose consciousness or fall over as a result of dizziness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have a bone or joint problem that could be aggravated by physical activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has a doctor ever recommended medication for your blood pressure or a heart condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you aware, through you own experience or a doctor's advice, of any other physical reason against your exercising without medical supervision? | <input type="checkbox"/> | <input type="checkbox"/> |

Name: _____ Signature _____ Date: _____
(if less than 18 years of age, responses were answered by parent/guardian whose name and signature appear above)

IF YES TO ONE OR MORE QUESTIONS: Consult with your family physician concerning those questions before increasing your physical activity or performing an exercise test.

IF NO TO ALL QUESTIONS: You can be reasonably assured that you can participate in a graduated exercise program. A graduated increase in proper exercise promotes good fitness development while minimizing or eliminating discomfort.

It is recommended that you postpone fitness testing if you have a minor illness/cold.

MEDICAL RECORDS RELEASE

If you would like us to send a copy of your medical records to your personal Healthcare Provider, please authorize as follows:

I WOULD LIKE MY MEDICAL RECORDS SENT TO THE FOLLOWING PHYSICIAN AND I HEREBY AUTHORIZE RELEASE OF MY MEDICAL RECORDS:

Physician's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

(Signature / Parent or guardian)

(Date)