New Jersey Sports Medicine and Performance Center

689 Valley Road · Suite 104 · Gillette · NJ · 07933
www.njsportsmed.com
(908) 647 – 6464

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE

PATIENT NAME:____**DATE:**________________

MEDICATIONS: ____

ALLERGIES: ____

PAST MEDICAL HISTORY: NONE OTHER: ____

	YES	**NO**
1. Has a doctor ever said you have a heart condition?		
2. Has a doctor ever recommended medically supervised physical activity?		
3. Do you have chest pain, dizziness, or shortness of breath with physical activity?		
4. Have you had chest pain within the past month?		
5. Have you ever lost consciousness or fallen as a result of dizziness?		
6. Do you have a bone or joint problem that could be aggravated by physical activity?		
7. Has a doctor ever recommended medication for your heart, lungs, or blood pressure?		
8. Are you aware, through you own experience or a doctor's advice, of any reason against you exercising without medical supervision?		

Name: ______________________________ Signature_________________________ Date:_________
(if < 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.

MEDICAL RECORDS RELEASE

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)