

PARTICIPANT ACTIVITY READINESS QUESTIONNAIRE

CIRCLE ONE

- | | | |
|---|-----|----|
| 1. Has a doctor ever said you have a heart condition and that you should only do physical activity recommended by a doctor? | YES | NO |
| 2. Do you feel pain in your chest when you do physical activity? | YES | NO |
| 3. In the past month, have you had chest pain when you are not doing physical activity? | YES | NO |
| 4. Do you lose your balance because of dizziness or do you ever lose consciousness? | YES | NO |
| 5. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? | YES | NO |
| 6. Do you have a bone or joint problem that could be made worse by a change in your physical activity? | YES | NO |
| 7. Do you know of any other reason why you should not do physical activity? | YES | NO |

**If you are over 69 years of age, and you are not used to being very active, check with your doctor.

MEDICATIONS

Please list all medications (including herbs and vitamins) that you are currently taking:

Name of Medication:	Dosage:	Taken for:

Do any of your medications affect your heart rate? If you are uncertain, please consult your physician.

I have reviewed these questions and answered them to the best of my ability. I understand that these materials will be reviewed and I may be asked to see my doctor before participating.

Date of Birth: _____ Age: _____

Signature: _____ Date: _____

Print name: _____ Witness Signature: _____