LIFESTYLE QUESTIONNAIRE

DATE: ______________

NAME: ____ D.O.B: ______________

ADDRESS: _______________________________________ TEL: ______________

_______________________________________ MOB: ________

_______________________________________ E-mail: ______________

Have you or do u suffer from any of the following (Circle where applicable)

ASTHMA	**ANGINA**	**HIGH BLOOD PRESSURE**
LOW BLOOD PRESSURE	**EPILEPSY**	**ARTHRITIS**
CONSTIPATION	**DIABETES**	**FREQUENT COLDS**
DIZZINESS/FAINTING	**HEART DISEASE**	**SHORTNESS OF BREATH**
HIGH CHOLECTROL	**HEADEACHES**	**MIGRAINS**
JOINT PAIN	**RHEUMATIC FEVER**	**OSTEOPROSIS**

Details (if any) : __________________________ __________________________________

Have you ever had a surgery? ______________ __________________________________

Have you ever broken any bones? _______ __________________________________

Are you sensitive to touch/pressure in any area? __________________________________

Do you experience swollen or painful joints? __________________________________

Was there any trauma relating to the pain? __________________________________

List any medications at present?_____________ __________________________________

On a scale of 1 to 10 (1=not active, 10=very active) how active are you? ____________________

Do you smoke? If so how many per 24 hours? ____

How many glasses of coffee, tea or coke do u have per day? __________________________

List 3 goals you would like to achieve by an exercise program?

____

____

____

All information in this form is correct to the best of my knowledge and have sought, and followed, any necessary medical advice.

All information will be kept confidential.

Signature & Date: __________________________

MEDICAL RELEASE FORM

Date: ………………………

Dear sir,

……………………………………………………… wishes to start an exercise program under my guidance.

As per the pre exercise questioner, this patient indicates the following areas, which are some concern to my self:

During a health/fitness assessment, the following factors were discovered, which are some concern to myself:

The proposed, tailored exercise program will consist of the following type of activities:

If your patient is taking any medication that may alter their heart rate during exercise, please indicate whether it lowers or raises the heart rate response:

MEDICATION: ____________________ **RESPOND:** ____________________

Can you please indicate any recommendations or restrictions if nay that would appropriate to your patient in an exercise program?

……
……
……
……

Sincerely, **…………………………………**

DOCTOR:
………………………………………………………………………has my approval to start a supervised exercise program, with recommendations and restrictions stated above.
Name: __ Date: __ Address: __ Sign/stamp:
Tel / E-mail: __________________________

MALDIVES NATIONAL INSTITUTE OF SPORTS