

## Health Screening Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Tel: \_\_\_\_\_

1. Are you currently exercising or physically active?  No  Yes

2. Describe your current exercise program / physical activity

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3. Have you been diagnosed with osteoporosis?  No  Yes

4. Have you had a fracture?  No  Yes

5. Have you had a fall in the last 12 months  No  Yes

6. Has a doctor ever told you not to exercise?  No  Yes

7. Please check those conditions you have now, or have had in the past.

Heart problems including chest pain with activity (angina)

Stroke

High blood pressure

Other chronic illness (please outline below)

Recent surgery

Bronchitis, asthma or emphysema

Significant joint problems

Significant back pain that persisted

Previous injury that is still affecting you

Diabetes

Smoking

High cholesterol

Heart problems in the immediate family

Vision impairment

Hearing impairment

Please put any additional comments here: \_\_\_\_\_

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