



Exercise performance pre-test questionnaire

Name _____ DOB _____ Age _____

Address _____

Home phone _____ Work phone _____

E-mail _____

Primary healthcare provider _____ Insurance _____

Medications and dose _____

Supplements _____

Do you follow a particular diet? (please describe) _____

Allergies _____ None

Major Medical problems _____

Previous surgeries _____

When was your last physical? _____

Has your doctor ever said you have had heart trouble? Y N

Do you frequently have pains in your chest or heart? Y N

Do you often feel faint or have spells of severe dizziness? Y N

Did your doctor ever tell you your blood pressure was high ? Y N

Have your first-degree relatives (that is, parents, sisters, brothers of children) developed heart disease or died suddenly at an early age (that is before 55 if male; before 65 if female)? Y N



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If your fasting blood glucose (sugar) 110 mg/dl or higher Y N Unknown

Have you ever had a cholesterol level checked. Y N

If yes, results Total Cholesterol_____ HDL_____ LDL_____ Triglycerides_____

Have you ever had an EKG Y N

If yes, results _____

What do you consider a good weight for yourself? _____

Females: Last pap test _____ Mammogram _____ Bone density test _____

Do you have regular periods? Y N When was your last period? _____

Are you currently pregnant or breastfeeding? Y N

Family History

History of disease	Father	Mother	Sibling	Grandparents	Children
Heart Disease					
Sudden death before age 55					
Diabetes					
High Blood Pressure					
High cholesterol					
Stroke					
Thyroid disease					
Asthma					
Genetic disorder (hemophilia, marfan's syndrome)					
Obesity					
Cancer (if so, what type)					



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Social history

What kind of work do you do _____

How many hours of work/week _____

Stress level at work 1-5 (5 highest) _____

Single Married Divorced Widowed

How supportive is significant other of your sport 1-5 (5 very supportive) _____

Children (Names and ages)

Do you use tobacco (cigarettes/cigars/chew) Y N

Have you ever regularly used tobacco Y N

If you quit, when did you quit _____

Do you drink alcoholic beverages Y N

If so, what kind of alcohol Wine Beer Mixed Drinks

If yes, how many drinks/week _____

Athletic performance questions

What is your primary sport? _____

What other sports do you like/participate in? _____

Do you belong to a gym? Y N If yes, which one? _____

Are you training for a particular event? If so, what and when _____



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Do you have a goal for this event? If so, what? _____

I have been training consistently for _____ weeks/months/years

Describe your typical week of training

Monday _____

Tuesday _____

Wednesday _____

Thursday _____

Friday _____

Saturday _____

Sunday _____

Cardio/endurance:

Number of workouts/week _____ Number of hours working out/week _____

Average duration of workouts _____ Intensity of workouts _____

Strength:

Number of workouts/week _____

Average Sets _____

Average Reps _____



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Please describe any other workouts you do workouts (yoga, pilates. Etc)

Do you have any concerns about your weight? If so, what _____

Do you keep a workout log? Y N

Do you use a heart rate monitor? Y N

What are your strengths in your particular sport?

What are your weaknesses in your particular sport?

Briefly describe your overall exercise goals

What do you hope to get out of this session?