YOUR HEALTH NORFOLK

Pre-Exercise Health Questionnaire

Name:..... D.O.B:.....

Address:.....

.....

.....

Gender: Male ☐ Female ☐ GP Surgery:.....

Home Telephone..... Mobile:.....

Email.....

Would you like to opt in to receive our newsletters and emails? Yes ☐ No ☐

Emergency contact name and relation:.....

Their contact number:.....

"I have read, understood and completed the form above. All questions have been answered to the best of my knowledge. I agree to take part in the programme described to me by my trainer. The nature, purpose, risks and benefits have been explained to me and I understand what is required of me and that I may withdraw at any time."

Full Name:.....

Signature:..... Date:.....

Thank you,

YourHealthNorfolk

PTO

Have you been diagnosed with any of the following?	If yes, then please give details:
☐ Heart Attack	.....
☐ Transient ischemic attack	.....
☐ Angina	.....
☐ High blood pressure	.....
☐ Stroke	.....
☐ Peripheral vascular disease	.....
☐ Diabetes	.....
☐ Neuropathies	.....
☐ Asthma / COPD	.....
☐ Parkinson's disease	.....
☐ Multiple sclerosis	.....
☐ Polio/post-polio syndrome	.....
☐ Epilepsy/seizures	.....
☐ Other neurological conditions	.....
☐ Osteoporosis	.....
☐ Rheumatoid arthritis	.....
☐ Other arthritic conditions	.....
☐ Visual/depth perception	.....
☐ Inner ear problems	.....
☐ Cerebellar problems (ataxia)	.....
☐ Other movement disorders	.....
☐ Chemical dependency	.....
☐ Depression	.....
☐ Cancers, if so, please state	.....