Triple Fitness Training, Inc.
HEALTH SCREENING PHYSICAL TRAINING QUESTIONNIARE

Common sense is your best guide in answering the below questions. Please check **YES** or **NO** opposite the question.

YES NO

( ) ( ) 1. Has your doctor ever told you that you have heart or lung problems?

( ) ( ) 2. Have you ever had any heart related problems?

( ) ( ) 3. Do you frequently feel faint or have spells of dizziness?

( ) ( ) 4. Do you frequently feel any chest discomfort or pain?

( ) ( ) 5. Has your doctor ever told you that you have a high blood pressure, or have you ever had high blood pressure in the past, or are you presently taking medications for high blood pressure?

( ) ( ) 6. Are you aware of any bone, back, or joint problems that may be or could be aggravated by exercise (e.g. arthritis)?

( ) ( ) 7. Have you ever had an episode of exercise induced asthma, i.e., severe wheezing, coughing or severe shortness of breath at rest or with mild exertion?

( ) ( ) 8. Do you ever have episodes of labored difficult breathing during the night where you have to sit up to breath?

( ) ( ) 9. Have you ever been told by your doctor that you have diabetes?

( ) ( ) 10. Are you over age 40 and not involved in regular exercise?

( ) ( ) 11. Is there any good reason not mentioned here why you should not engage in a systematic exercise training program?

( ) ( ) 12. Are you pregnant?

Date of Birth _____ Age _____

Comments: _____

_____

I hereby certify that the above information is correct.

_____ _____

Participant's Name (print) Address City St Zip Code Phone #

_____ _____

Participant's Signature Date

ANY "YES " RESPONSE CONCERNING CARDIOVASCULAR, PULMUNARY, OR METABOLIC PROBLEMS MAY NOT ENGAGE IN ANY FORMAL EXERCISE PROGRAM UNTIL A MEDICAL CLEARENCE FORM IS COMPLETED AND SIGNED BY AN APPROPRIATE PHYSCIAN.

MEDICAL CLEARENCE FORM

I hereby certify that, to the best of my knowledge, the person whose name is signed above, was physically examined and has no contraindications to participation in rigorous athletic training designed to enhance fitness and race performance.

Precautions and Limitations to Physical Training: _____

_____

_____

Patient's Name: _____

Signature of Physician: _____

Type or Printed Name: _____

Date: _____ Phone: _____

Physician's Address: _____

_____

_____

Triple Fitness Training, Inc.
263 Mounts Bay Court
Longwood, FL 32779
407-774-1147