# American Heart Association®/American College of Sports Medicine® Preparticipation Screening Questionnaire

**First Name**:__________________________ **MI**_____**Last Name**___________________________

☐ **Male** ☐ **Female** **Birthdate: / /** **Height:** ______ **Weight:**______

## ■ History

You have had:

_____ a heart attack
_____ heart surgery
_____ cardiac catheterization
_____ coronary angioplasty (PTCA)
_____ pacemaker/implantable cardiac defibrillator/rhythm disturbance
_____ heart valve disease
_____ heart failure
_____ heart transplantation
_____ congenital heart disease

## ■ Symptoms

_____ You experience chest discomfort with exertion.
_____ You experience unreasonable breathlessness.
_____ You experience dizziness, fainting, blackouts.
_____ You take heart medications.

## ■ Other health issues

_____ You have musculoskeletal problems.
_____ You have concerns about the safety of exercise.
_____ You take prescription medication(s). What are they? ___________________________
_____ You are pregnant, breastfeeding, or menstruating today.

## ■ Cardiovascular Risk Factors

_____ You are a man older than 45 years.
_____ You are a woman older than 55 years or have had a hysterectomy or are post menopausal.
_____ You have diabetes
_____ You smoke.
_____ Your blood pressure is > 140/90.
_____ You don't know your blood pressure.
_____ You take blood pressure medication.
_____ Your blood cholesterol level is > 240 mg/dl.
_____ You don't know your cholesterol level.
_____ You have a close blood relative who had a heart attack before age 55 (father or brother) or age 65 (mother or sister).
_____ You are physically inactive (ie, you get < 30 minutes of physical activity on at least 3 days per week.
_____ You are > 20 pounds overweight.

_____ None of the above are true.

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## AEROBIC ACTIVITIES

- Are you currently involved in a routine of regular exercise (moderate continuous exertion of at least 20 minutes duration on at least 3 days each week?) If NO, go to the next section RESISTANCE TRAINING ACTIVITIES. ☐yes ☐no
- How long have you been exercising regularly? _____yrs _____mos _____wks
- For the last month, which of the following activities have you performed regularly? Please check yes for all that apply and no if you do not perform the activity; provide an estimate of the amount of activity for all marked yes. Please be as complete as possible.

**walking** ☐ yes ☐ no

How many workouts per week and average duration in minutes? _____/_____

**jogging** / running ☐ yes ☐ no

How many workouts per week and average duration in minutes? _____/_____

**treadmill** ☐ yes ☐ no

How many workouts per week and average duration in minutes? _____/_____

**bicycling (outdoor)** ☐ yes ☐ no

How many workouts per week and average duration in minutes? _____/_____

**stationary cycling / other aerobic machine** ☐ yes ☐ no

How many workouts per week and average duration in minutes? _____/_____
Type of machine?

**swimming laps** ☐ yes ☐ no

How many workouts per week and average duration in minutes? _____/_____

**aerobic dance / floor exercises** ☐ yes ☐ no

How many workouts per week and average duration in minutes? _____/_____

**racquet sports** ☐ yes ☐ no

How many workouts per week and average duration in minutes? /
Type of racquet sport?

## RESISTANCE TRAINING ACTIVITIES

- Are you currently involved in a muscle strengthening program? ☐ yes ☐ no
  If yes, please select all that apply:
  ☐ calisthenics ☐ free weights ☐ weight training machines ☐ other

  How many workouts per week and average duration in minutes? _____/_____

## OCCUPATIONAL RELATED PHYSICAL ACTIVITIES

- How active are you at work on most days?

Select on of the following:

☐ **very light** – mostly sitting or standing

☐ **light** – walking, light lifting, light packing some of the time

☐ **moderate** – walking, light-moderate lifting/carrying, half of the time or more

☐ **physical** – brisk walking, lifting/carrying heavy objects more than half the time

# EXERCISE METABOLISM ASSESSMENT

## Informed Consent

### ■ Purpose and Explanation of the Assessment

You will perform a fitness assessment on a cycle ergometer or a motor-driven treadmill. The exercise intensity will begin at a low level and may be advanced in stages depending on your fitness level. We may stop the assessment at any time because of signs of fatigue or changes in your heart rate, electrocardiogram (ECG) if recorded, or blood pressure if recorded, or symptoms you may experience. ***It is important for you to realize that you may stop at any point you wish because of feelings of fatigue or any other discomfort.***

### ■ Attendant Risks and Discomforts

There exists the possibility of certain changes occurring during the assessment. These include abnormal blood pressure, fainting, irregular, fast or slow heart rhythm, and in rare instances, heart attack, stroke, or death. Every effort will be made to minimize these risks by evaluation of preliminary information relating to your health and fitness and by careful observations during the assessment. Emergency protocols have been established to deal with unusual situations that may arise.

### ■ Responsibilities of the Participant

Information you possess about your health status or previous experiences of heart-related symptoms (such as shortness of breath with low-level activity, pain, pressure, tightness, heaviness in the chest, neck, jaw, back and/or arms) with physical effort may affect the safety of your fitness assessment. Your prompt reporting of these and any other unusual feelings with effort during the assessment itself is of great importance. You are responsible for providing complete and accurate information on the American Heart Association/American College of Sports Medicine Preparticipation Screening Questionnaire. You are responsible for fully disclosing your medical history, as well as symptoms that may occur during the assessment. You are also expected to report all medications (including nonprescription) taken recently and, in particular, those taken today, to the assessment staff.

### ■ Benefits to be Expected

The results obtained from the fitness assessment may assist in evaluating your cardiorespiratory fitness and formulating an individualized exercise program for you.

### ■ Inquiries

Any questions about the procedures used in the assessment or the results of your assessment are encouraged. If you have any concerns or questions, please ask us for further explanations.

### ■ Use of Assessment Results

The information that is obtained during the fitness assessment will be treated as

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privileged and confidential. It is not to be released or revealed to any person except your referring physician without your written consent. The information obtained, however, may be used for statistical analysis or scientific purposes with your right to privacy retained.

■ **Freedom of Consent**

I hereby consent to voluntarily engage in a fitness assessment to determine my cardiorespiratory fitness. I acknowledge that I have either been given my physician's permission to perform this cardiorespiratory fitness assessment or that I have decided to perform this cardiorespiratory fitness assessment without the approval of my physician. My permission to perform this assessment is given voluntarily. I understand that I am free to stop the assessment at any point, if I so desire.

I have read this form, and I understand the assessment procedures that I will perform and the attendant risks and discomforts. Knowing these risks and discomforts, and having had an opportunity to ask questions that have been answered to my satisfaction, I consent to voluntarily participate in this assessment.

I do hereby waive, release and forever discharge Affiliated Community Medical Centers, P.A., its officers, agents, employees, representatives, executors, and New Leaf™ Health & Fitness Products/Angeion Corporation and its officers, agents, employees, representatives, executors, and all others from any and all responsibilities or liability for injuries or damages resulting from my participation in any activities recommended or supervised by Affiliated Community Medical Centers, P.A. staff and New Leaf Health & Fitness Products/Angeion Corporation. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, including those caused by the negligent act of omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities of Affiliated Community Medical Centers, P.A. and NewLeaf Health & Fitness Products/Angeion Corporation.

________________________ ________________________________________
Date Signature of Client/Patient