Dr. Miguel Chiacchio
Medicina de la Educación Física
y el Deporte

juaneda

Medical Questionnaire Prior to Exercise Testing

This data is confidential. Please place an "**X**" in the boxes. Write clearly and in block capital letters. Please add any relevant questions or additional notes at the end. The form **must be completed by over 18 years of age,** and preferably having consulted family member/s. **Ensure both pages are signed.**

Surname ....

Christian Name .... Date of birth……………………

Address ....

Post Code .... City .... Phone ....

Preferred Sport .... Sports Club ……………………………............. Date ………………..

Email Address... @ ....

	Medical History	**Yes**	**No**
1	Is it more than 2 years since you last had a medical examination including checking your blood pressure and listening to your heart?	☐	☐
2	Do you take any medication that could affect you during this exercise?	☐	☐
3	Do you have a) asthma b) epilepsy or seizures c) anemia d) haemophilia	☐	☐
4	Is there any reason or illness to prevent you carrying out sporting activities (i.e. Eg Osteoarthritis, cancer, renal, liver o thyroid disease?	☐	☐
5	Do you have diabetes ?	☐	☐
6	Could you be pregnant ?	☐	☐
7	Do you have any medical problems with your eyes, kidneys or testicles, or have you Had any of these removed?	☐	☐
8	Do you use glasses or contact lens ?	☐	☐
9	Do you use prosthetics in your eyes, mouth or ears ?	☐	☐
	Medical Symptoms		
10	Have you ever been told you have an enlarged heart, heart problems or a heart murmur ?	☐	☐
11	Have you ever had any of the following symptoms during or after exercise: a) pains, discomfort or pressure in your chest or arms b) pains in your legs c) dizziness d) fainting or lightheadedness ?	☐	☐
12	Have you ever had any of the following symptoms during or after exercise: a) difficulty breathing b) palpitations, a feeling of heart missing a beat, or heart beating abnormally strongly c) sickness, abdominal discomfort or strange feeling of indigestion d) unusual fatigue?	☐	☐
13	Have you ever had a) swollen ankles b) breathlessness through the night that awakens you?	☐	☐

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	Risk factors	Yes	No
14	Do you a) smoke b) have high blood pressure c) have high cholesterol?	☐	☐
15	Has anyone in your family died suddenly **before age 50 years** (due to heart disease, car accident, drowning or other causes)?	☐	☐
16	Does your family have a history of heart disease lke angina , heart attacks, infarction or atherosclerosis **before the age of 50 years** (mother, father, sister, brother)?	☐	☐
17	Are you aware of any cardiac conditions in family members, or incidents of fainting, or seizures?	☐	☐
18	Have you a) missed any periods b) had the menopause before the age of 45 c) take hormone replacement medication ?	☐	☐
	Physical exercise		
19	Do you do any physical activities ?	☐	☐
20	What type of activity or sport do you do?:		
21	At what intensity do you practise sports a) no sport or low b) medium c) high		
22	How long have you been carrying out this sport : a) 0-3 months b) 3-12 months c) more than 12 months		
23	How many days a week: 1 – 2 – 3 – 4 – 5 – 6 - 7		
24	How many minutes a session? :		
25	If you don't currently do any physical activities, do you now intend to start exercising? and at what intensity? a) no intention to exercise b) intention to commence moderate exercise c) intention to commence intensive physical activity		
	TAS *TAD* *Colesterol* *HDL* *LDL* *Triglicéridos*		

Any further information or questions?

Signature Patient / Parent / Guardian

Medical notes: