Mile High Multisport

HEALTH & MEDICAL QUESTIONNAIRE

Name: _____ Date of Birth: _____
Date: _____

In case of emergency, whom may we contact?

Name: _____ Relationship: _____

Phone (Cell):_____ (Home):_____

Personal physician

Name: _____ Phone: _____
Fax: _____

Present/Past History

Have you had or do you presently have any of the following? (Check if yes.)

_____ Rheumatic fever

_____ Recent operation

_____ Edema (swelling of ankles)

_____ High blood pressure

_____ Low blood pressure

_____ Injury to back or knees

_____ Seizures

_____ Lung disease

_____ Heart attack or known heart disease

_____ Fainting or dizziness

_____ Diabetes

_____ High Cholesterol

_____ Orthopnea (the need to sit up to breathe comfortably) or paroxysmal (sudden, unexpected attack) or nocturnal dyspnea (shortness of breath at night)

_____ Shortness of breath at rest or with mild exertion

_____ Chest pains

_____ Palpitations or tachycardia (unusually strong or rapid beat)

_____ Intermittent claudication (calf cramping)

_____ Pain, discomfort in the chest, neck, jaw, arms, or other areas

_____ Known heart murmur

_____ Unusual fatigue or shortness of breath with usual activities

_____ Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side, arm, or
leg of your body

_____ Cancer

_____ Other (please describe): _____

Family History

Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions? (Check if yes.) In addition, please identify at what age the condition occurred.

_____ Heart attack

_____ Heart operation (Bypass surgery, Angioplasty, Coronary Stent placement)

_____ Congenital heart disease

_____ High blood pressure

_____ High cholesterol

_____ Diabetes

_____ Other major illness: _____

Explain checked items :

_____
_____
_____
_____

Activity History

1. 1. Have you ever worked with a triathlon coach before? Y/N
2. Date of your last physical examination performed by a physician: _____
3. Can you currently walk 4 miles briskly without fatigue? Y/N
4. Have you ever performed resistance training exercises in the past? Y/N
5. Do you have injuries (bone or muscle disabilities) that may interfere with exercising? Y/N If yes, briefly describe: _____
6. Do you smoke or use tobacco products? Y/N If yes, how much per day and what was your age when you started? Amount per day _____ Age _____
7. What is your body weight now? _____What was it one year ago? _____
8. At age 21? _____
9. How tall are you? _____
10. Do you follow or have you recently followed any specific dietary intake plan and, in general, how do you feel about your nutritional habits?
    a. _____ _____ _____ _____
11. List the medications you are presently taking.
    a. _____ _____ _____

Signature _____

Printed Name _____

Date _____/_____/_____