

Screening Questionnaire

1. Has a doctor ever said you have heart trouble?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you ever had angina pectoris, sharp pain, or heavy pressure in your chest as a result of exercise, walking, or other physical activity such as climbing stairs (Note: this does not include the normal out of breath feeling that results from normal activity.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Do you experience any sharp pain or extreme tightness in your chest when you are hit with a cold blast of air?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you ever experienced rapid heart action or palpitations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you ever had a real or suspected heart attack, coronary occlusion, myocardial infarction, coronary insufficiency, or thrombosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Have you ever had rheumatic fever?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Do you have diabetes, hypertension or high blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Does anyone in your family have diabetes, hypertension or high blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Has more than one blood relative (parent, sibling, first cousin) had a heart attack or coronary artery disease before the age of 60?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Have you ever taken any medication to lower your blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Have you ever taken medications or been on a special diet to lower your cholesterol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Have you ever taken digitalis, quinine, or any other drug for your heart?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Have you ever taken nitroglycerine or any other tablets for chest pain - tablets you take by placing under the tongue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Are you overweight?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. Are you under a lot of stress?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Do you drink excessively?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. Do you smoke cigarettes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
18. Do you have a physical condition, impairment or disability, including a joint or muscle problem, that should be considered before you undertake an exercise program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
19. Are you more than 65 years old?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
20. Are you more than 35 years old?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
21. Do you exercise fewer than three times per week?	<input type="checkbox"/> Yes	<input type="checkbox"/> No