Matson Cycle Coaching

PAR-Q & Medical History Questionnaire

All information will be strictly confidential.

Name: _____

Date of Birth: _____

Check with your doctor before beginning a new fitness program. This is particularly true if you are over 40, if you smoke, or if you have a family history of cardiovascular disease, high blood pressure, elevated cholesterol, diabetes, arthritis or asthma.

Physical Activity Readiness Questionnaire (Par-Q)

For most people physical activity should not pose any problem or hazard. The Par-Q has been designed to identify adults for whom physical activity might be inappropriate or those who should have medical advice concerning the type of activity most suitable for them.

Common sense is your best guide in answering these questions. Please read them carefully and check **YES** or **NO** if it applies to you. If a question is answered with **YES**, *please use another sheet of paper to provide follow up detail; we will also discuss this in a follow-up conversation.*

1. Has a doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? ☐**YES** ☐**NO**
2. Do you feel pain in your chest when you do physical activity? ☐**YES** ☐**NO**
3. In the past month, have you had chest pain when you were not doing physical activity? ☐**YES** ☐**NO**
4. Do you lose your balance because of dizziness or do you ever lose consciousness? ☐**YES** ☐**NO**
5. Do you have a bone or joint problem that could be made worse by a change in your physical activity? ☐**YES** ☐**NO**
6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? ☐**YES** ☐**NO**
7. Do you know of any other reason why you should not do physical activity? ☐**YES** ☐**NO**

Make sure to inform your doctor and your coach if any of the above answers should change from NO to Yes.

Please complete the questions on the next page.

Medical History

Cardiovascular Disease Risk Factor

Has a doctor or health professional ever told you that you have any of the following conditions?

- ☐ Heart Disease
- ☐ Family history of heart disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Obesity
- ☐ Lack of physical activity
- ☐ Diabetes
- ☐ Impaired fasting glucose
- ☐ High HDL (negative risk factor)

Medication Use

Are you currently taking any of the following medications:

- ☐ Blood Pressure Medication
- ☐ Cholesterol Medication
- ☐ Blood Sugar Medication
- ☐ Heart Medication
- ☐ Other Medication(s).

Please list:

In addition to the physical activity ready questions above, please tell me a little about your medical history. This information will help me understand your background and any conditions that might affect your training. Please answer the following questions YES or NO. You can add specific details on another sheet of paper, or I will follow up any YES answers in our introductory conversations and you can give more specific details. Also, please do not feel limited by the form or its questions. Write or tell me any information you think I should know about your medial history and your readiness for physical activity.

1.	Do you currently participate in any training or fitness program?	❑ YES ❑ NO
2.	Do you currently exercise 4 hours per week or more?	❑ YES ❑ NO
3.	Are you allergic to any medication?	❑ YES ❑ NO
4.	Do you have any allergies that require medical treatment?	❑ YES ❑ NO
5.	Have you ever had a severe allergic reaction to insect bites or stings?	❑ YES ❑ NO
6.	Do you use an inhaler?	❑ YES ❑ NO
7.	Have you ever been a regular smoker?	❑ YES ❑ NO
8.	Do you use any dietary supplements?	❑ YES ❑ NO
9.	Do you have frequent or severe headaches?	❑ YES ❑ NO
10.	Have you ever become ill from exercising in the heat?	❑ YES ❑ NO
11.	Have you ever had muscle cramps while exercising?	❑ YES ❑ NO
12.	Have you ever been told to give up sports because of health problems?	❑ YES ❑ NO
13.	Have you ever had a concussion or become unconscious because of an injury or blow to the head?	❑ YES ❑ NO
14.	Have you ever had an injury to bones or joints that required hospitalization or surgery?	❑ YES ❑ NO
15.	Specifically, have you ever had a serious injury to your neck, spine, or knees?	❑ YES ❑ NO
16.	Do you have knee or back pain?	❑ YES ❑ NO
17.	Do you have a pin, screw, or plate in your body?	❑ YES ❑ NO
18.	Do you wear glasses or contacts to correct your vision?	❑ YES ❑ NO
19.	Do you have a hearing loss?	❑ YES ❑ NO
20.	Do you have other medical conditions? Anything else you would like me to know?	❑ YES ❑ NO

Overall State of Health

How would you rate your overall state of health?

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Excellent