UNIVERSITY OF THE WEST of SCOTLAND
UWS

Institute of Clinical Exercise and Health Science

Medical Questionnaire for Physiological Testing

Before any physiological tests are carried out on you, we will have to check whether you are in a satisfactory condition to undergo submaximal tests. We would therefore like you to fill in the following questionnaire about yourself. All information will be treated as strictly confidential.

Name Date of Birth

Specialist Sport (if any) Male ☐ Female ☐

PLEASE TICK THE CORRECT RESPONSE

1. Have you ever had a heart attack, coronary revascularisation surgery or a stroke?

No ☐ **Yes** ☐

2. Has your doctor ever told you that you have heart trouble or vascular disease?

No ☐ **Yes** ☐

3. Has your doctor ever told you that you have a heart murmur?

No ☐ **Yes** ☐

4. Do you ever suffer from pains in your chest, especially with exercise?

No ☐ **Yes** ☐

5. Do you ever get pains in your calves, buttocks or at the back of your legs during exercise which are not due to soreness or stiffness?

No ☐ **Yes** ☐

6. Do you ever feel faint or have spells of severe dizziness, particularly with exercise?

No ☐ **Yes** ☐

7. Do you experience swelling or accumulation of fluid about the ankles?

No ☐ **Yes** ☐

8. Do you ever get the feeling that your heart is suddenly beating faster, racing or skipping beats, either at rest or during exercise?

No ☐ **Yes** ☐

9. Do you have chronic obstructive pulmonary disease, interstitial lung disease, or cystic fibrosis?

No ☐ **Yes** ☐

10. Have you ever had an attack of shortness of breath that developed when you were not doing anything strenuous, at any time in the last 12 months?

No ☐ **Yes** ☐

11. Have you ever had an attack of shortness of breath that developed after you stopped exercising, at any time in the last 12 months?

No ☐ **Yes** ☐

12. Have you ever been woken at night by an attack of shortness of breath, at any time in the last 12 months?

No ☐ **Yes** ☐

13. Do you have diabetes [Type I (Insulin-dependent diabetes mellitus (IDDM)) or Type II (non-insulin dependent diabetes mellitus (NIDDM)]? If so, do you have trouble controlling your diabetes?

No ☐ **Yes** ☐

14. Do you have any ulcerated wounds or cuts on your feet that do not seem to heal?

No ☐ **Yes** ☐

15. Do you have any liver, kidney or thyroid disorders?

No ☐ **Yes** ☐

16. Do you experience unusual fatigue or shortness of breath with usual activities?

No ☐ **Yes** ☐

17. Is there any other physical reason or medical condition, or are you taking any medication(s) which could prevent you from undertaking an exercise program, or that you are concerned about? If so, please explain.*(see notes)

No ☐ **Yes** ☐

18. Have you suffered from a viral infection in the last two weeks?

No ☐ **Yes** ☐

*** NOTES: Some of these conditions might include a history of blood clotting, osteoporosis, bone fractures or serious musculoskeletal disorders, or if they have recently lost a weight without trying to. Other types of conditions might include psychiatric disorders, later-stage pregnancy or those with a history of health problems**

during pregnancy. Those people taking medication(s) for medical conditions listed may also need medical clearance.

- ¬ **I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction. If there will be a change of status to any of the conditions above I will inform the researcher or the senior academic involved IMMEDIATELY.**

NAME SIGNATURE DATE

To be completed by test supervisor: **MUST BE SIGNED BEFORE THE SUBJECT STARTS EXERCISE**		
Checked by	**Signed**	**Date**