(608) 884-1489

Exercise Risk Assessment Form
Yoga

Name________________________________ Gender_______ Age_______

Address______________________________ City____________ State______

Zip________________ Email Address________________________________

Phone_____________________

Please provide the following information as accurately and completely as possible.

Known Cardiovascular, Pulmonary or Metabolic Disease

□ Yes □ No Myocardial infarction ("heart attack")___________________________
□ Yes □ No Stroke or ischemic attack ("mini stroke")________________________
□ Yes □ No Other cardiovascular disease/disorder (aneurysm, etc.)____________
□ Yes □ No Asthma or chronic obstructive pulmonary disease (COPD, etc.)______
□ Yes □ No Diabetes (Type I, Type II, etc.)___________________________________
□ Yes □ No Other____

Other Information Concerning Personal Health History
Do you have a personal history of any of the following?

□ Yes □ No Diagnosed back/neck disorder_________________________________
□ Yes □ No Currently under doctor's care for back/neck disorder______________
□ Yes □ No Been to doctor within the past year for back pain_________________
□ Yes □ No Joint surgery, joint pain or joint swelling_______________________
□ Yes □ No Osteoporosis ("low bone density")______________________________
□ Yes □ No Occasional significant numbness or weakness_____________________
□ Yes □ No Balance or gait problems_______________________________________
□ Yes □ No Sit for 30 hours or more per week during work___________________

*Comment:*____

Physical Activity Readiness Questionnaire (PAR-Q)

□ Yes □ No Has your doctor ever said you have a heart condition and should only do physical activity recommended by a doctor?
□ Yes □ No Do you feel pain in your chest when you do physical activity?

☐ Yes ☐ No In the past month, have you had chest pain when you were not physically active?

☐ Yes ☐ No Do you lose balance because of dizziness or do you ever lose consciousness?

☐ Yes ☐ No Do you have a bone or joint problem that could be made worse by a change in your physical activity?

☐ Yes ☐ No Is your doctor currently prescribing drugs for your blood pressure or heart condition?

☐ Yes ☐ No Do you know of any other reason why you should not do physical activity?

*Comment:*____

Drugs/Medications

Please list any prescription or over the counter (OTC) drugs/medications you are currently taking.

Drug/Medication	Purpose/Reason for Taking
______________________________	____
______________________________	____
______________________________	____
______________________________	____

In Case of Emergency (Must be completed)

Name___________________________________ Relationship____________________

Phone_____________________________ Cell____________________________________

Upon completion of this form, <u>I declare and understand the following</u>:

Initial

______ I have completed this health history to the best of my recollection and have not knowingly withheld any information concerning my health history.

_______________________________ ____________

Signature Date

Please return this form when completed and signed to:

Angie Sullivan/Community Education Coordinator
Edgerton Hospital and Health Services
313 Stoughton Road
Edgerton, WI 53534

04/14/08