CONFIDENTIAL MEDICAL QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS

DO YOU SUFFER, OR HAVE SUFFERED FROM ANY OF THE FOLLOWING?

DESCRIPTION	NO	YES-Please give details
Heart Disease?		
Family History of Heart disease/Strokes?		
Chest Complaints e.g. Asthma/Bronchitis?		
High Blood Pressure?		
Fainting or Dizziness?		
Circulatory/Blood problems?		
Epilepsy/Seizures/Fits?		
Major Surgery?		
Do you regularly take prescribed drugs?		
Bone/joint conditions?		
Do you drink Alcohol?		
Bone or Joint injury?		
Lower Back Pain or injury?		
Do you take regular exercise?		
Do you smoke?		
Has your doctor ever advised you against exercise due to injury/illness?		
Are there any other Medical Conditions you feel we should know about?		

DECLARATION

I understand that whilst every care will be taken to give safe instruction, I accept full responsibility and consider myself fit to exercise. I have answered all questions correctly and all medical and health considerations are noted above.

PLEASE NOTE IT IS YOUR RESPONSIBILITY TO INFORM YOUR INDIVIDUAL INSTRUCTOR OF ANY MEDICAL CONDITION THAT MAY AFFECT YOUR HEALTH WHILST UNDER THEIR INSTRUCTION AS THE INFORMATION DECLARED ON THIS FORM IS NOT PASSED ON TO ANYONE

SIGNED: _____ PRINT: _____ DATE: _____

If under 18 a parent or guardian must sign. All given information is protected under the Data Protection Act