# KBPT

## MEDICAL SCREENING

### PERSONAL DETAILS

Name: .....
Address: .....
D.O.B: .....
Mobile Number: .....
Email address: .....

1 Have you suffered or are you suffering from any of the following? (please tick)

[ ] Gout
[ ] Stroke
[ ] Diabetes
[ ] Epilepsy
[ ] Hernia
[ ] Heart condition
[ ] High blood pressure
[ ] Dizziness or fainting
[ ] Glandular fever
[ ] Liver/kidney condition
[ ] Palpitations or chest pains
[ ] Stomach problems

If ticked, please give details: .....
.....
.....

2 Has anyone in your family under the age of 60 suffered from heart disease or raised cholesterol?

[ ] YES [ ] NO

If yes, please give details: .....
.....
.....

3 Are you taking any prescribed medication?

[ ] YES [ ] NO

If yes, please give details: .....
.....
.....

4 Do you have any pain or injury, particularly in the region of the neck, back, knees or ankle?

[ ] YES [ ] NO

If yes, please give details: .....
.....
.....

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5 Have you had any operation during the past 12 months? Have you ever had joint replacement?

[ ] YES [ ] NO

If yes, please give details: .....
.....
.....

6 Are you pregnant?

[ ] YES [ ] NO

7 Do you smoke?

[ ] YES [ ] NO

8 Is there any other aspect of your health not mentioned above that may affect the prescription of an exercise program?

[ ] YES [ ] NO

If yes, please give details: .....
.....
.....

## DECLARATION

I, the undersigned, have read, understood, and answered the above questions fully and truthfully. I am aware of my responsibilities to consult with my G.P. regarding my medical fitness to engage in exercise. I do hereby intend to be legally bound for myself and waive release of any and all rights and claims for damages I may have against the exercise professional administering the exercise program provided to me.

Client: ..... Date: .....

Trainer: ..... Date: .....