Medical History and Risk Factor Questionnaire

Name: _____Today's Date: _____

Date of Birth: _____ Age: _____

The information contained on this document is considered strictly confidential and will be used only by the BFC Ministry Instructor Team for purposes of modifying program offerings and/or in the event of a medical emergency.

Medical History:

Are you fully vaccinated against COVID 19? ____ YES ____ NO ____Do not wish to disclose

Have you ever had, do you currently have, or are you taking medication for, any of the following?

☐ Anemia	☐ Memory loss
☐ Arthritis -type/location _____	☐ Osteoporosis/Osteopenia
☐ Asthma	☐ Parkinson's Disease
☐ Cancer-Type _____	☐ Phlebitis
☐ Cardiac Condition/Event-Type _____	☐ Pulmonary Disorder
☐ Diabetes	☐ Shortness of breath
☐ Fainting/Dizziness	☐ Stroke/TIA – date:
☐ High Blood pressure	☐ Thyroid Disorder
☐ High Cholesterol	☐ Other Medical Condition _____
☐ Hypoglycemia	☐ **None – if none above apply**

If you checked any box above, please provide dates and details: _____

_____

_____

Are you currently receiving or have you in the last year had treatment or been hospitalized for any condition or received physical, occupational or speech therapy? _____ YES _____NO

If **YES**, when, what type and for what reason _____

If YES, within the previous month, a *Statement of Medical Clearance* will also be required from your provider/physician.

Do you have any other medical conditions which would affect your ability to exercise safely?

_____**YES** _____**NO** If **YES**, explain _____

_____

Have you ever had a serious injury, fracture, or surgery? _____ YES _____ NO

If **YES**, when, type and what location of body: _____

_____

Please answer the following:

Are you experiencing any pain?	YES	NO	If yes, explain below
Do you have problems with balance?	YES	NO	If yes, explain below
Do you have any movement limitations?	YES	NO	If yes, explain below
Has your doctor given you any restrictions regarding exercise?	YES	NO	If yes, explain below

_____

_____

Do you take any medications? If YES, please list all including over the counter.

Medication	Dose	Purpose	Medication	Dose	Purpose

Physical Activity History

What is your current activity level? ☐ Active ☐ Moderately Active ☐ Slightly Active ☐ Inactive

How long have you been exercising? _____

How intensely do you exercise: ☐ Light ☐ Moderate ☐ Hard

What type of exercise do you perform? _____

What type of equipment have you used?_____

What is your goal with BFC Exercise or BFO? _____

Are there any physical movements you would like to be able to do more easily? _____

_____

Is there anything else you would like to share about your medical or exercise history? _____

_____