



# Union County Family YMCA

## PAR – Q & YOU

(A Questionnaire for People Age 15 to 69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly.

### Check YES or NO:

- | YES   | NO    |   |
|-------|-------|---|
| _____ | _____ | 1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? |
| _____ | _____ | 2. Do you feel pain in your chest when you do physical activity?  |
| _____ | _____ | 3. In the past month, have you had chest pain when you were not doing physical activity?  |
| _____ | _____ | 4. Do you lose your balance because of dizziness or do you ever lose consciousness?   |
| _____ | _____ | 5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?                              |
| _____ | _____ | 6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?                |
| _____ | _____ | 7. Do you know of <u>any other reason</u> why you should not do physical activity?  |

### **If you answered YES to one or more questions**

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want – as long as you start slowly and build up gradually. Or you may need to restrict your activity to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

### **If NO to all questions**

If you answered NO honestly to all PAR-Q questions you can be reasonably sure that you can:

- Start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- Take part in fitness appraisal – this is an excellent way to determine your basic fitness so then you can plan the best way for you to live actively.

Delay becoming much more active:

- If you are not feeling well because of a temporary illness such as a cold or fever – wait until you feel better, or
- If you are or may be pregnant – talk to your doctor before you start becoming more active.

**Please note:** If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

Informed Use of the PAR-Q: The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity and if in doubt after completing this questionnaire, consult you doctor prior to physical activity.

“I have read, understand and completed this questionnaire. Any question I had were answered to my full satisfaction.”

Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent \_\_\_\_\_ Witness \_\_\_\_\_

Or Guardian (for participants under the age of majority)

**Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.**

## HEALTH/MEDICAL HISTORY QUESTIONNAIRE

### PERSONAL INFORMATION:

NAME: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_-\_\_\_\_-\_\_\_\_ WORK PHONE \_\_\_\_-\_\_\_\_-\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_ GENDER: M \_\_\_ F \_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

IF MINOR, PARENT'S NAMES: \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_ PHYSICIAN PHONE NUMBER: \_\_\_\_-\_\_\_\_-\_\_\_\_

PHYSICIAN'S ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

LIST ANY CHRONIC ILLNESS FOR WHICH YOU SOUGHT MEDICAL CARE:

\_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

### **HOSPITALIZATIONS:**

<u>YEAR</u>	<u>REASON</u>
_____	_____
_____	_____

ALLERGIES TO MEDICATIONS: \_\_\_\_\_

LIST CURRENT MEDICATIONS: \_\_\_\_\_

DO YOU SMOKE? YES NO IF YES HOW MUCH PER DAY? \_\_\_\_\_

HOW MANY YEARS? \_\_\_\_\_

## **FAMILY HISTORY**

LIST ANY IMMEDIATE FAMILY MEMBER(S) WHO HAVE BEEN DIAGNOSED WITH OR WHO HAVE DIED FROM ANY OF THE FOLLOWING CONDITIONS:

CONGESTIVE HEART FAILURE: \_\_\_\_\_

DIABETES: \_\_\_\_\_

HEART ATTACK: \_\_\_\_\_

HIGH BLOOD PRESSURE: \_\_\_\_\_

STROKE: \_\_\_\_\_

**HAVE YOU EVER HAD OR BEEN TOLD THAT YOU HAVE: (CIRCLE YES OR NO. IF THE ANSWER IS YES, PLEASE INDICATE IF THE CONDITION IS CURRENT OR WAS IN THE PAST. IF IN THE PAST, PLEASE INDICATE THE DATE IT OCCURRED.)**

<b><u>CONDITION</u></b>	<b><u>STATUS</u></b>				<b><u>DATE</u></b>
ANEMIA	NO	YES	CURRENT	PAST	____/____/____
ANGINA	NO	YES	CURRENT	PAST	____/____/____
ARTHRITIS (OSTEO)	NO	YES	CURRENT	PAST	____/____/____
ARTHRITIS(RHEUMATIOD)	NO	YES	CURRENT	PAST	____/____/____
ASTHMA	NO	YES	CURRENT	PAST	____/____/____
ASTHMA(EXERCISE IND.)	NO	YES	CURRENT	PAST	____/____/____
BRONCHITIS	NO	YES	CURRENT	PAST	____/____/____
BURSITIS	NO	YES	CURRENT	PAST	____/____/____
CHRONIC FATIGUE SYNDROME	NO	YES	CURRENT	PAST	____/____/____
CORONARY ARTERY DISEASE	NO	YES	CURRENT	PAST	____/____/____
DEPRESSION	NO	YES	CURRENT	PAST	____/____/____
DIABETES	NO	YES	CURRENT	PAST	____/____/____
EMOTIONAL DISORDERS	NO	YES	CURRENT	PAST	____/____/____
EMPHYSEMA	NO	YES	CURRENT	PAST	____/____/____
ENLARGED HEART	NO	YES	CURRENT	PAST	____/____/____
EPILEPSY	NO	YES	CURRENT	PAST	____/____/____
HEART ATTACK	NO	YES	CURRENT	PAST	____/____/____
HEART MURMUR	NO	YES	CURRENT	PAST	____/____/____
HERNIA	NO	YES	CURRENT	PAST	____/____/____
HEPATITIS	NO	YES	CURRENT	PAST	____/____/____
HIGH BLOOD PRESSURE	NO	YES	CURRENT	PAST	____/____/____
HIGH BLOOD CHOLESTEROL	NO	YES	CURRENT	PAST	____/____/____
IRREGULAR HEART BEAT	NO	YES	CURRENT	PAST	____/____/____
KIDNEY DISEASE	NO	YES	CURRENT	PAST	____/____/____
LOW BLOOD PRESSURE	NO	YES	CURRENT	PAST	____/____/____
PERIPHERAL VASCULAR D.	NO	YES	CURRENT	PAST	____/____/____
PHEUMONIA	NO	YES	CURRENT	PAST	____/____/____
PHEUMATIC FEVER	NO	YES	CURRENT	PAST	____/____/____
THYROID DISEASE	NO	YES	CURRENT	PAST	____/____/____
TUBERCULOSIS	NO	YES	CURRENT	PAST	____/____/____
ULCER DISEASE	NO	YES	CURRENT	PAST	____/____/____
YELLOW JAUNDICE	NO	YES	CURRENT	PAST	____/____/____

ANY OTHER CONDITION NOT LISTED: \_\_\_\_\_

HAVE YOU PREVIOUSLY HAD A TREADMILL STRESS TEST? YES NO

IF YES, WHERE: \_\_\_\_\_

WHEN: \_\_\_\_\_

RESULT: \_\_\_\_\_

HAVE YOU EVER EXPERIENCED ANY OF THE FOLOWING?

CHEST PAIN OR HEAVINESS WITH EXERCISE	YES	NO
CHEST PAIN OR HEAVINESS WITH DAILY ACTIVITY OR AT REST	YES	NO
IRREGULAR HEART BEAT, PALPITATIONS, HEART SKIPPING BEATS	YES	NO
DIZZYSPELLS OR LIGHT-HEADEDNESS	YES	NO
WAKING UP IN THE MIDDLE OF THE NIGHT TO CATCH YOUR BREATH	YES	NO
UNEXPLAINED SHORTNESS OF BREATH	YES	NO
SHORTNESS OF BREATH WHEN LYING FLAT	YES	NO
SLEEPING ON MORE THAN ONE PILLOW TO PREVENT SHORTNESS OF BREATH	YES	NO
PAINFUL OR SWOLLEN JOINTS	YES	NO
BLOOD IN URINE	YES	NO

ANY OTHER MEDICAL PROBLEMS NOT ALREADY INDICATED: \_\_\_\_\_

## **EXERCISE PROFILE**

DO YOU HAVE ANY TYPE OF BIOMECHANICAL JOINT PROBLEMS?

YES\_\_\_ NO\_\_\_ IF YES, EXPLAIN: \_\_\_\_\_

DO YOU CURRENTLY HAVE ANY EXERCISE-INDUCED INJURIES?

YES\_\_\_ NO\_\_\_ IF YES, EXPALIN: \_\_\_\_\_

HAVE YOU HAD A PREVIOUS EXERCISE-INDUCED INJURY?

YES\_\_\_ NO\_\_\_ IF YES, EXPLAIN: \_\_\_\_\_

WERE MEDICAL CARE AND/OR PHYSICAL THERAPY INVOLVED?

YES\_\_\_ NO\_\_\_

ARE YOU CURRENTLY INVOLVED IN ANY TYPE OF EXERCISE ROUTINE?

YES\_\_\_ NO\_\_\_ IF YES, EXPLAIN: \_\_\_\_\_