AlfredHealth

☐ Alfred ☐ Sandringham ☐ Caulfield

Unit:………………………………….

UR:

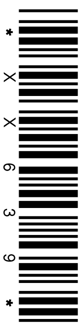
Family Name

Given Names

Date of Birth

Gender: ☐ Male ☐ Female

HEALTH ASSESSMENT QUESTIONNAIRE
(for Physical Activity participation)



Thank you for taking the time to complete this questionnaire – please bring it to your first/next appointment

Family Name: ______________________________ Given Name/s: ______________________________

Date of Birth: ______________________________ Address: ______________________________

______________________________ Post Code: ______________________________

Phone: Home:______________________________ Mobile: ______________________________

Person to contact in case of emergency:

Name & relationship: ______________________________ Phone: ______________________________

Doctors name: ______________________________ Phone: ______________________________

PLEASE ASK YOUR DOCTOR to complete this section and sign it. Any information considered appropriate to your participation in physical activity should be added:

MEDICAL HISTORY (tick if present and add relevant details):

☐ Osteoporosis ☐ High/Low blood pressure ☐ Asthma/COAD

☐ Diabetes - Type ______________________________ ☐ Falls/trips

☐ Musculoskeletal condition/Arthritis - where ______________________________

☐ Heart condition - ☐ Pacemaker ☐ AMI/Angina/Arrythmia

☐ Neurological conditions - details ______________________________

☐ Fainting or dizzy spells - vestibular/migraines/other ______________________________

Other significant/relevant ______________________________

MEDICATIONS:

Blood Pressure: ___________Resting Heart Rate: ________Hba1c (if applicable): ____________

Bone Density (if applicable): ______________________________

RESTRICTIONS OR PRECAUTIONS:

Doctor's Name and phone number: ______________________________

Doctor's signature: ______________________________ Date: ..... / ..... / .....

Date Created: Apr 2016
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Scanned to: Assessments

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