LINDENWOOD UNIVERSITY
EXERCISE AND PERFORMANCE NUTRITION LABORATORY

Health and Fitness Pre-Participation Screening Questionnaire

Directions. The purpose of this questionnaire is to enable the staff of the Exercise and Performance Nutrition Laboratory and the School of Health Sciences to evaluate your health and fitness status and to determine your level of readiness to begin a research study or complete various certain physiological assessments. Please answer the following questions to the best of your knowledge. All information given is **CONFIDENTIAL** as described in the **Informed Consent Statement.**

Name: ____ **Age:** ________ **Gender:** Male Female

Cell Phone: ____________________________________ **Email:** ____

Ethnicity: __________________________________ **Height:** __________ **Weight:** ___________

HISTORY

You have had:

____ a heart attack
____ heart surgery
____ cardiac catheterization
____ heart valve disease
____ heart transplantation
____ heart failure (or congenital heart failure)
____ coronary angioplasty (Percutaneous Transluminal Coronary Angioplasty)
____ a pacemaker and/or an implantable cardiac defibrillator installed in your chest
____ heart rhythm disturbances (atrial fibrillation [Afib], ventricular tachycardia [Vtach], or ventricular fibrillation [Vfib])
____ heart failure (or congenital heart failure)
____ heart transplantation
____ congenital heart failure

SYMPTOMS

____ You experience chest discomfort with exertion
____ You experience unreasonable breathlessness
____ You experience dizziness, fainting, or blackouts
____ You experience ankle swelling
____ You experience unpleasant awareness of a forceful or rapid heart rate
____ You take heart medications

CARDIOVASCULAR RISK FACTORS

____ **You do not know your blood pressure**
____ **You take a blood pressure medication**
____ **You smoke or quit smoking within the previous 6 months**
____ **Your blood cholesterol level is >200 mg/dL**
____ **You do not know your blood cholesterol level**

Are you taking any medications, vitamins, or dietary supplements now? Y N

If yes, what are they? ____

____

Are you allergic to latex? Y N

Are you allergic to lidocaine? Y N

Do you have allergies to any other medications? If yes, what are they?

____

Have you been seen by a health care provider in the past year? Y N

If yes, elaborate on the reason for the visit: ____

Have you ever experienced any adverse effects during or after exercise (fainting, palpitations, hyperventilation)? Y N

If yes, elaborate on what happened: ____

LIFESTYLE FACTORS

Do you now or have you ever used tobacco? Y N If yes: type _________________

How many years have you used tobacco? ______ years Quantity: _____ packs/day Years since quitting____________

How often do you drink the following?

Caffeinated coffee, tea, or soda _________oz/day Servings (drinks) of Alcohol Per Week __________

Indicate your current level of emotional stress. High______ Moderate ______ Low______

Indicate your current average hours of sleep per night. _____________

WOMEN ONLY

Are you currently using oral contraceptives? Y N If yes, type: ___________________________________

Are you currently using a hormonal IUD such as Mirena, Skyla, or Liletta? Y N