REGISTRATION & HEALTH SCREENING FORM

Name: ____

Address: ____

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Contact No: ______________________

Date of Birth:______________________

Occupation: ______________________

E-mail Address: _________________________________

Doctor's Name: ____________________________________

Address: ____

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Person to contact in case of Emergency:

Name: ____

Phone: ______________________

Are you taking any medication or drugs at present. If so, please list medication, dose and reason.

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Does your physician know you are participating in this exercise programme ______

What is your current level of fitness? Describe any physical activity that you do somewhat regularly

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Do you now or have you had in the past:

1.	**History of heart problems, chest pain or stroke**	**Yes** ☐	**No** ☐
2.	**Increased blood pressure**	**Yes** ☐	**No** ☐
3.	**Any chronic illness or condition**	**Yes** ☐	**No** ☐
4.	**Difficulty with physical exercise**	**Yes** ☐	**No** ☐
5.	**Advise from physician not to exercise**	**Yes** ☐	**No** ☐
6.	**Recent surgery (last 12 months)**	**Yes** ☐	**No** ☐
7.	**Pregnancy (now or within the last 3 months)**	**Yes** ☐	**No** ☐
8.	**History of breathing or lung problems**	**Yes** ☐	**No** ☐
9.	**Muscle, joint or back disorder or any previous injury still affecting you**	**Yes** ☐	**No** ☐
10.	**Diabetes or thyroid condition**	**Yes** ☐	**No** ☐
11.	**Cigarette smoking habit**	**Yes** ☐	**No** ☐
12.	**Obesity (more than 20% over ideal body weight)**	**Yes** ☐	**No** ☐
13.	**Increased blood cholesterol**	**Yes** ☐	**No** ☐
14.	**History of heart problems in immediate family**	**Yes** ☐	**No** ☐
15.	**Hernia, or any condition that may be aggravated by lifting weights**	**Yes** ☐	**No** ☐

Please explain if you have answered "yes" to any of the above

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INFORMED CONSENT

I acknowledge to the best of my ability that I am in good health and I have no known medical problems that would restrict my ability to participate in an exercise programme.

Signed: ___________________________________ **Date:** ___________________