Par Q Form

Name: _____ Date: _____

Telephone: _____

E-Mail: _____

Date of Birth:_____ Age: _____ Height: _____ Weight:_____

In Case of Emergency Contact: _____ Relationship:_____

Address: _____ Phone: _____

Physician: _____ Specialty: _____

Address: _____ Phone: _____

Are you currently under a doctor's care: Yes ☐ No ☐

If yes, explain: _____

When was the last time you had a physical examination? _____

Have you ever had an exercise stress test: Yes ☐ No ☐ Don't Know ☐

If yes, were the results: Normal ☐ Abnormal ☐

Do you take any medications on a regular basis? Yes ☐ No ☐

If yes, please list medications and reasons for taking: _____

Have you been recently hospitalized? Yes ☐ No ☐

If yes, explain: _____

Do you smoke? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐

Do you drink alcohol more than three times/week? Yes ☐ No ☐

Is your stress level high? Yes ☐ No ☐

Are you moderately active on most days of the week? Yes ☐ No ☐

Do you have:

High blood pressure? Yes ☐ No ☐

High cholesterol? Yes ☐ No ☐

Diabetes? Yes ☐ No ☐

Rheumatic heart disease? Yes ☐ No ☐

A heart murmur? Yes ☐ No ☐

Chest pain with exertion? Yes ☐ No ☐

Irregular heart beat or palpitations? Yes ☐ No ☐

Lightheadedness or do you faint? Yes ☐ No ☐

Unusual shortness of breath?	Yes ☐ No ☐
Cramping pains in legs or feet?	Yes ☐ No ☐
Emphysema?	Yes ☐ No ☐
Other metabolic disorders (thyroid, kidney, etc.)?	Yes ☐ No ☐
Epilepsy?	Yes ☐ No ☐
Asthma?	Yes ☐ No ☐
Back pain: upper, middle, lower?	Yes ☐ No ☐
Other joint pain (explain on back of form)?	Yes ☐ No ☐
Muscle pain or an injury (explain on back of Form)?	Yes ☐ No ☐

Have parents or siblings who, prior to age 55 had:	Yes ☐ No ☐
A heart attack?	Yes ☐ No ☐
A stroke?	Yes ☐ No ☐
High blood pressure?	Yes ☐ No ☐
High cholesterol?	Yes ☐ No ☐
Known heart disease?	Yes ☐ No ☐

To the best of my knowledge, the above information is true.

Signature _____

Date_____ Witness _____