Tina Sarracino
Exercise Physiology

Date: / /

Medical Information Form

PERSONAL INFORMATION

- This is a risk factor screening form which must be completed prior to arrival for your first session.
- The information obtained will be kept confidential.
- Please ensure you bring copies of any relevant reports, scans or other information to your assessment.
- It is best to wear loose comfortable clothing to your assessment session and to bring a towel.
- If you have any questions or concerns, please do not hesitate to contact Tina to obtain more information.

Personal Details			
Name:		Date of Birth:	
Ph:	Mob:	Gender: M / F	Age:
Email address:			
Address:			
		Postcode:	State:

General Practitioner Details	
Physician Name:	
Ph:	Fax:
Practice/Surgery Address:	

Emergency Contact Details		
Name:		Relationship:
Ph:	Mob:	

Tina Sarracino
Exercise Physiology
ESSAM AEP

Phone (07) 3720 9971
Fax (07) 3720 9971
Mobile 0439 732 867
Email exercise.physiology@aol.com.au

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Medicare/Health Fund Details	
Medicare Number:	DVA Number (if Applicable):
Health Fund:	

LIFESTYLE HISTORY

Please answer the following Lifestyle related questions Do you or have you experienced any of the following conditions? (Please tick the appropriate column and give details)

Smoking			
Are you or have you ever been a smoker?	Past / Current (Please circle)	Age you started?	Age you quit?
Average number of cigarettes smoked per day			

Alcohol Consumption
How many drinks do you consume per week on average?

Body Weight	
Has your weight fluctuated more than a few kilo's during the past 12 months? YES / NO	If so, by how much? (kg)

Physical Activity	
What is your current level of physical activity?	ACTIVE / INACTIVE
Details:	

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MEDICAL CONDITIONS

Do you or have you experienced any of the following conditions?
(Please tick the appropriate column and give details)

Condition	YES	NO	DETAILS
Stroke			
Cancer			
Sight/Hearing impairments			
Hereditary Conditions			
Other Concerns			
Other Conditions			

Cardiac concerns	YES	NO	DETAILS
Heart Attack			
Angina/ Chest Pain			
Heart Disease			
Do you experience any discomfort in your chest?			
Other			

Respiratory Concerns	YES	NO	DETAILS
Bronchitis			
Emphysema			
Asthma			
Unexplained Shortness of breath at rest			
Shortness of breath when walking			
Other			

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Neurological Concerns	YES	NO	DETAILS
Epilepsy			
Multiple sclerosis			
Parkinson's Disease			
Other			

Psychological Concerns	YES	NO	DETAILS
Depression			
Anxiety			
Other			

Musculoskeletal Concerns	YES	NO	DETAILS
Joint Pain			
Back Pain			
Osteoarthritis			
Osteoporosis			
Other			

Circulatory Concerns	
Do you experience swelling of your feet and ankles?	YES / NO
Do you get pains or cramps, tingling, numbness, or loss of feeling in your arms, hands, legs, feet or face?	YES / NO
Comments:	

Blood Pressure		
Have you ever been told that your blood pressure was abnormal?	YES / NO	HIGH / LOW
If YES do you take medication for this? (If YES, please list)		YES / NO
Comments:		

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Cholesterol	
Have you ever been told that your serum cholesterol or triglyceride level was high?	YES / NO
If you can remember, what was your last reading?	
Are you taking medication for this? (If YES, please list)	YES / NO
Comments:	

Diabetes			
Do you have diabetes?			YES / NO
If Yes which type?	(Type 1) Insulin Dependant	(Type 2) Non-Insulin Dependant	
If YES how do you control your condition?	Average blood glucose reading:		
Year of diagnosis:	Family history?		
Complications?			
Recent hypoglycaemic episode (frequency / severity):			

Bone Density Health			
Have you previously been tested for osteoporosis and had your bone mineral density reported?			YES / NO
What was your diagnosis?	Normal Bone Density ☐	Osteopenia ☐	Osteoporosis ☐
Are you, or have you ever been on medication to strengthen your bones? (If YES, please list)			YES / NO
Have you ever broken or damaged a bone as a result of a minor trauma? (Please include vertebral crush fractures)			YES / NO
Details:			

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Surgical/Medical Procedures	
Have you ever undergone medical surgery?	YES / NO
Details (procedure, year, rehabilitation etc):	

Hormone Replacement Therapy	
Do you or have you ever used HRT (Hormone Replacement Therapy)? (If YES, please list)	YES / NO

CURRENT MEDICATIONS

Please name and give dosage of the medicines that you are currently taking

Medication	Dose (mg/day or tablets/day)	Reason for Medication (plus any additional comments	How long have you been taking this? (months & years)

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Disclaimer

The information I have supplied in this form I hereby declare is true and correct. I have answered the questions to the best of my ability and understand that Tina Sarracino (and any who work with her) cannot provide me with medical advice.

I will inform my instructor immediately should I feel any symptoms or if I suffer any injuries throughout the course of my activities (directly or indirectly related to the specific exercises provided by Tina Sarracino), and I will inform them should my health status change from what is described in this medical screening form.

I will consult my GP before I commence in this program (particularly if I have never exercised before) to ensure they are aware of my intentions to undertake an activity program, and that they feel I am medically safe to undertake such a program. I request that my GP also provide recommendations on the attached GP Medical Consent form, regarding special considerations that they feel are applicable to my participation in such activities.

I will consult my GP regularly to inform them of my progress in the program and seek recommendations from them with respect to increasing intensity at which I work out in the classes.

I agree to follow the directions given by Tina Sarracino (and any who work with her), and I will exercise at my own pace.

I authorise Tina Sarracino (and any who work with her) and my GP to communicate about my progress, and understand that they are both bound by the privacy act and will only use information that is pertinent to my exercise program and medical condition as it relates.

I understand that this form will remain the possession of Tina Sarracino, and in accordance with the privacy act, will only be used for the initial exercise prescription and monitoring of my progress in the program.

I understand that I may be required to undertake a health and fitness assessment that will measure my: height, weight, body composition, blood pressure, flexibility, muscle strength and functional well-being.

I have read, understood and am in agreement with the above statements (please sign below):

_____

(Participant)

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