

Healthy Steps to an Active Lifestyle
Pre-Participation Health Screening* (Required for CRS Memberships)

This is for **YOU** to complete to the best of your ability.

Assess your health by marking all *true* statements.

History

You have had:

- a heart attack
- heart surgery
- cardiac catheterization
- coronary angioplasty (PTCA)
- pacemaker/implantable cardiac defibrillator/rhythm disturbance
- heart valve disease
- heart failure
- heart transplantation
- congenital heart disease

Symptoms

- You experience chest discomfort when exertion
- You experience unreasonable breathlessness
- You experience dizziness, fainting, or blackouts
- You take heart medications

Other Health Issues

- You have diabetes
 - You have asthma or other lung disease
 - You have burning or cramping sensation in your lower legs when walking short distances
 - You have musculoskeletal problems that limit your physical activity
 - You have concerns about the safety of exercise
 - You take prescription medications
 - You are pregnant
-

Cardiovascular risk factors

- You are a man older than 45 years
 - You are a woman older than 55 years, have had a hysterectomy, or are postmenopausal
 - You smoke, or quit smoking within the previous 6 months
 - Your blood pressure is >140/90 mm Hg
 - You do not know your blood pressure
 - You take blood pressure medication
 - Your blood cholesterol level is >200 mg/dL
 - You do not know your cholesterol level
 - You have a close blood relative who had a heart attack or heart surgery before age 55 (father or brother) or age 65 (mother or sister)
 - You are physically inactive (i.e. you get <30 minutes of physical activity on at least 3 days per week)
 - You are >20 pounds overweight
-

None of the above

*Based on the answers you provide on this screening, you may be required to meet with a qualified health professional for a more thorough evaluation.

IMPORTANT ó OVER ó IMPORTANT

Adelphi University

Rj {ukekcpøu"Engctcepeg"hqt"Rj {ukecn"Cevkxkv{

(Required for CRS Memberships)

This is for **YOUR PHYSICIAN** to complete

Dear Doctor:

Your patient is interested in recreational, physical fitness activities at Adelphi University and we would like your opinion regarding the relative safety of his/her participation. Minimally supervised activities may include, but are not limited to strength training with resistance equipment, free-weights and the use of aerobic exercise modalities, such as treadmills, stationary bikes, steppers, elliptical trainers, etc. Group exercise classes, lap swimming and the use of an indoor track are also potential alternatives. Opportunities for professionally supervised exercise participation, including a fitness evaluation and individually tailored program and are also available. By completing this form, you are not assuming any responsibility for our exercise and assessment program.

Rcvkgpøu"Pc o gaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa"Fcvgaaaaaaaaaaaaaaaaaaaa

Rj {ukekcpøu"Pc o g"*rngcug"rtkpv+"aa

Phone _____ Address _____

Rj {ukekcpøu"Uki pcwvtgaa_____

Physician's Office Stamp (Required)

Please Check One:

- My patient should NOT participate in a physical activity program at this time.
- My patient can participate in physical activity with no medical limitations.
- My patient can participate in an exercise program with the following considerations or limitations and should be professionally supervised.

