Mums on the Run Solihull Par Q Form

Name: _____ Date: _____

Mobile Number: _____

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

In Case of Emergency Contact: _____ Relationship:_____

Phone:_____

GP Name and Surgery Address:_____

Phone: _____

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

If yes, explain: _____

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

How many times a week are you moderately active and if so, what activities do you do:

_____

Do you have:

High blood pressure? Yes No

Allergies and if YES, which? Yes No

_____

High cholesterol? Yes No

Diabetes? 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
Rheumatic heart disease?	Yes No
A heart murmur?	Yes No
Do you suffer from or have you ever suffered from:	
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

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

Signature _____

Date_____ Witnessed by Coach _____