HUMAN PERFORMANCE RESEARCH LABORATORY

SUBJECT INFORMATION AND MEDICAL HISTORY

NAME:____ DATE____________________

ADDRESS:____ PHONE:__________________

____ EMAIL:__________________

OCCUPATION:____

GENDER: M__ F___ AGE________yrs DATE OF BIRTH__________________

Items below are to be filled out by HPRL Staff:

WEIGHT__________kg HEIGHT_________cm BP____/____mmHg HR_________beats/min

TOTAL CHOLESTEROL___________mg/dL HDL_______ mg/dL LDL________ mg/dL TG___________mg/dL

FASTING BLOOD GLUCOSE ___________________mg/dL Other blood results:__________________________

MEDICAL HISTORY: (Please Circle your Answer/s)

Are you currently taking any **medications**: Yes or No:

If yes, please list:____

Please list *all **medical conditions*** (i.e. ulcers, arthritis, mono, hepatitis, HIV, muscloskeletal injury)?____________________

____

Please list any **hospitalizations** and/or **surgeries**?____

Have you ever been diagnosed with a **breathing problem** such as asthma? Yes or No:

If yes, please explain:____

Have you ever been diagnosed with a **heart problem** or condition? Yes or No:

If yes, please explain:____

Do ***you*** have any of the following symptoms at *rest* or with *low to moderate physical activity*? Yes or No:

Lightheadedness Shortness of Breath Chest Pain Numbness

Fatigue Coughing Wheezing Other__________________

If yes, pleas explain:____

Do ***you*** have any of following *cardiovascular disease risk factors*? Yes or No

Family History of Heart Attacks Hypertension Hypercholesterolemia Phyiscal Inactivity

Diabetes Current cigarette smoker Obesity

If yes, please explain:____

Do you have ***an immediate family member*** with any of the following *diseases*? Yes or No

Diabetes Hypertension Hypercholesterolemia Obesity

If yes, please explain:____

Are there ***any other conditions*** that might *affect* ***your health/exercise ability***? Yes or No:

If yes, please explain:____

Physical Activity / Training History / Body Composition

Do you engage in regular physical activity – more than 30 minutes of physical activity at moderate intensity for at least 4-5 times a week? *Please circle* **Yes or No**

Please list the mode/s or type of exercise you engage in during a typical week____

What is/are the frequency/ies of your exercise session/s per week?____

What is/are the duration/s of your exercise session/s?____

What is/are the intensity of your exercise bout/s?____

What is the total volume of your workouts per week (hrs per week)____

How many years have you been physically active?____

Have you ever performed a fitness or maximal exercise test? Yes or No:

If yes, what were the results of your tests? ECG___________________ VO2 max________________

Workload________________ % BF _______________

Overall Interpretation:____

Have you gained a significant amount of weight or consider yourself 20 pounds overweight? Yes or No:

If yes, please expalin____

Women Only:

Please indicate how many menstrual cycles you have had within the past 12 months:___________________________________

Are you taking oral contraceptives or estrogen replacement therapy? Yes or No:

If yes, please indicate type and brand:____

Competitors or Athletes:

Do you perform hard/high intensity intervals in your training or consider yourself a competitive athlete? Yes or No:

If yes, please explain (list recent personal bests or awards)____

Cardiovascular and Physical Fitness Goals

What do you hope to gain from cardiovascular and physical fitness testing?____

____

Comments/Observations

____

____

____

ACSM OVERALL RISK STRATIFICATION:____

ACSM EXERCISE PARTICIPATION & EXERCISE TEST RECOMMENDATIONS:___________________________________

____