

POLYSPORT FITNESS ROOM - MEDICAL QUESTIONNAIRE

Personal Details

Name	
Date of Birth	
Age	

Emergency contact details

Name	
Relationship	
Telephone no.	
Doctor	
Telephone no.	

Medical History

Please tick one box in each section

Do you suffer from any of the following?	Diabetes	YES		NO	
	Asthma	YES		NO	
	Epilepsy	YES		NO	
	High blood pressure	YES		NO	
Are you currently taking medication?		YES		NO	

If so, please give details _____

Has your Doctor told you not to exercise?	YES		NO	
Has your doctor ever restricted you to certain types of exercise?	YES		NO	
Can you name any disorder or sports injuries you have had?	YES		NO	
Is there any reason why you should not take part in physical activity?	YES		NO	

Declaration

I hereby declare that I have read, understood and completed this questionnaire to the best of my knowledge. I also confirm that any questions I had were answered to my full satisfaction.

Signed _____ Date _____