VIOLET Study Health Questionnaire

Strictly confidential

Name:	**Date of Birth:**
Address: **Postcode:**	**GP name:** **Surgery:**
Telephone number: **Mobile number:**	**Emergency contact name:** **Emergency contact number:**
Any known allergies:	

Has a doctor ever told you that you have, or have had, any of the following conditions? If the answer is YES to any questions please give some details, including dates where possible.

High blood pressure?	Yes /No
Any heart conditions? Angina / MI	Yes / No
Stroke / Blood clots / TIA's / PVD?	Yes /No
Asthma?	Yes / No
COPD / any other breathing disorder?	Yes /No

Diabetes? Type I / Type II	Yes / No
Have any joint, back or neck pain?	Yes / No
Have you any known arthritis? RA / OA / Other	Yes / No
Have you had a recent injury within last 6 months?	Yes / No
Have you had surgery within last 6 months?	Yes / No
Have you any other medical condition not listed? e.g. cancer, thyroid, epilepsy, hernias etc.	Yes / No
Do you feel pain in your chest at rest or during physical activity?	Yes / No
Do you have unexplained breathlessness?	Yes / No
Do you ever have dizzy spells or faint?	Yes / No
Are you currently taking any tablets prescribed by your GP? Please list:	Yes / No
Do you require any special considerations due to a physical disability?	Yes / No
Do you smoke? Within the last 5 years?	Yes / No Yes / No
Have you fallen in the past year? How many times (approximately)?	Yes / No
Do you have any problems with your bones? e.g. osteoporosis	Yes / No

Can you get down onto the floor and up again unaided?	Yes / No

All the information given is correct.
I will inform the instructor if my medical condition or medication changes in any way.

Client signature:.....

Date: .....

Instructor signature:.....

Date: .....