Please complete the Health Questionnaire

Name:…….. Date of Birth:……...

Telephone Number:……

E-Mail Address:……

Next of Kin:…… Contact No:…….

Do you suffer from any of the following?

Angina	Yes / No
Asthma	Yes / No
Back Problems	Yes / No
Chest Pains	Yes / No
Diabetes	Yes / No
Dizzy Spells or Fainting	Yes / No
Epilepsy	Yes / No
High Blood Pressure	Yes / No
Joint Problems	Yes / No
Have you recently had an operation or illness?	Yes / No
Are you pregnant?	Yes / No
Have you been pregnant within the last 6 months?	Yes / No
Are you taking any medication of which the instructor should be aware of?	Yes / No
Has your Doctor ever said that you have a heart condition?	Yes / No
Do you have any injuries or problems that might restrict your participation in an exercise programme?	Yes / No
Is there any other reason why you should not participate in physical activity?	Yes / No

If you have answered *yes* to any of the above, please give details:

_____.

_____.

Signature:…….. Date:……