Advanced Care
PHYSICAL THERAPY, AQUATIC & FITNESS CENTER
Personal care that gets you results.

# Cardiovascular Health Pre-Activity Screening

***For each of the following questions, please place a check mark by each item that directly applies to you.***

1. ❑ Age: Men > 45  Women > 55
2. ❑ Family history: MI or sudden death before 55 years of age for father, other first-degree male relative, or 65 years of age for mother or female first-degree relative.
3. ❑ Cigarette Smoker: (Current or quit in the past six months)
4. ❑ Hypercholesterloemia:
   Total cholesterol >200 mg/dL
   LDL cholesterol > 130 mg/dL
   HDL < 40 mg/dL
5. ❑ Hypertension: Blood pressure–Systolic BP greater than or equal to 140 mmHg or diagnostic BP greater than or equal to 90mmHg, or on antihypertensive medications.
6. ❑ Impaired fasting glucose: fasting blood glucose greater than or equal to 100 mg/dL
7. ❑ Obesity: Body Mass Index >30 or waist circumference > 40 (men) and > 35 (women)
8. ❑ Sedentary lifestyle: Not meeting the minimum physical activity guidelines of the U.S. Surgeon General's Report

***Place a check in the line below that applies to the member.***

❑ Apparently healthy:
Asymptomatic and apparently healthy with no more than one major coronary risk factor.
Risk factors: ______________________
______________________
______________________

❑ Moderate risk:
Individuals who have signs or symptoms of possible cardiopulmonary or metabolic disease and/or two or more major coronary risk factors. Physician's note needed.
Risk factors: ______________________
______________________
______________________

❑ High risk/known disease:
Individuals with known cardiac, pulmonary, or metabolic disease. Physician's note needed.
Risk factors: ______________________
______________________
______________________

I declare that I have completed Advanced Care Fitness Inc.'s pre-activity screening questionnaire and/or health/medical information questionnaire and that I am physically able to participate in physical activity. Furthermore, I acknowledge that Advanced Care Fitness Inc. has advised me to obtain a physician's clearance in the event their answers on either the pre-activity screening questionnaire and/or health/medical information questionnaire indicates that I should not participate in a program of physical activity without a physician's clearance, or if Advanced Care Fitness Inc. is unsure of my physical health yet I maintain that I am physically capable of pursuing physical activity in Advanced Care Fitness Inc. without such steps being taken or has done so.

Individual's signature:______________________________ Date:______________

Staff witness signature:______________________________