



**PHYSICAL EDUCATION, HEALTH and RECREATION DEPARTMENT
2010 - 2011**

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE

Directions: Please answer the following questions about your medical history by "Yes" or "No", And Explain all "Yes" responses in the box bellow the questions:

No.	Medical History	Yes	No
1	Have you had a medical illness or injury since your last check-up?		
2	Do you have an ongoing or chronic illness?		
3	Are you currently being treated for an injury or condition?		
4	Have you ever had surgery?		
5	Are you currently taking any prescription medications?		
6	Have you ever been dizzy during or after exercise?		
7	Have you ever had chest pain during or after exercise?		
8	Do you get tired more quickly than your friends during exercise?		
9	Have you had high blood pressure or high cholesterol?		
10	Has a doctor ever denied or restricted your participation in sports for any heart problems?		
11	Do you have any current skin problems (for example, itching, rashes, acne, fungus,)?		
12	Have you ever had a head injury or concussion?		
13	Do you have e frequent or severe headaches?		
14	Have you ever had numbness or tingling in your arms, hands, legs, or feet?		
15	Have you ever become ill from exercising in the heat?		
16	Do you cough, wheeze, or have trouble breathing during or after activity?		
17	Do you have asthma?		
18	Do you use an inhaler?		
19	Have you had any problems with your eyes or vision?		
20	Have you broken or fractured any bones or dislocated any joints?		

Explanation "Yes" answers here:

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I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Students Name:

Students # :

Home Phone:

Students Signature: