

- OSU Employee
- Non-OSU Employee

Name _____

Exercise Risk Assessment

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people; however, some people should check with their doctor before they start becoming much more physically active. This Exercise Risk Assessment has been designed to identify the small number of adults for whom physical activity might be inappropriate or those who should have medical advice concerning they type of activity most suitable for them.

Common sense is your best guide in answering these questions. Please read them carefully and circle YES or NO opposite the question as it applies to you.

- | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------|------------|-----------|
| 1. Has a doctor ever said that you have a heart condition? | Yes | No |
| 2. Do you feel pain in your chest when you do physical activity? | Yes | No |
| 3. In the past month, have you had chest pain when you were not doing physical activity? | Yes | No |
| 4. Do you lose your balance because of dizziness or do you ever lose consciousness? | Yes | No |
| 5. Do you have a bone or joint problem that <u>could be made worse by physical activity</u> ? | Yes | No |
| 6. Is your doctor currently prescribing drugs for your blood pressure, diabetes or heart condition? | Yes | No |
| 7. Do you have any special needs in planning for exercise?
(For example, oxygen, amputation, wheelchair bound, etc)
If yes, _____ | Yes | No |

*Please note: If your health changes so that you answer yes to any of the above questions, tell your fitness professional. Ask whether you should change your physical activity plan

I understand my signature signifies that I have read and understand all the information on the questionnaire, that I have truthfully answered all the questions, and that any questions/concerns I may have had have been addressed to my complete satisfaction.

Signature _____

Date: _____

PLEASE COMPLETE OTHER SIDE

The OSU Center for Wellness and Prevention
2050 Kenny Road, Suite 1010 Columbus, OH 43221

MEMBER INFORMATION: (please print)

NAME: _____
Last First Middle Initial

DATE OF BIRTH: _____

ADDRESS: _____
Apt #

City State Zip Code

HOME PHONE NUMBER: (_____) _____ -- _____

WORK PHONE NUMBER: (_____) _____ -- _____

If you would like to receive e-mail updates from CWP, please provide e-mail

Are you a current OSU employee? Yes No

EMERGENCY CONTACT INFORMATION

NAME: _____

RELATION: _____

PHONE NUMBER: (_____) _____ -- _____

(_____) _____ -- _____

Staff Use Only

MRN# _____