

PHYSICAL ACTIVITY READINESS MEDICAL EXAMINATION

(PAR-MEDX) QUESTIONNAIRE FORM

SUMMARY OF THE PAR-MEDX FORM

As you have previously filled out a PAR-Q Form and have answered YES to any questions listed, these further screening questions helps us to gain a better understanding about your medical condition(s). The main questions are in *Italics* and highlighted in yellow and if you Answer Yes to any of the main Questions if the medical condition is currently present, please answer the sub questions provided and see declaration below. We do hold a Level 3 Diploma in GP Exercise Referral Fitness Qualification for the reason of this form to ask further details.

NO	QUESTIONS	YES	NO
1	<i>Do you have Arthritis, Osteoporosis or Back Problems? (If NO, go to Question 2)</i>		
1a	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)		
1b	Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g. spondylolisthesis), and/or spondylolisthesis/pars defect (a crack in the bony ring on the back of the spinal column)?		
1c	Have you had steroid injections or taken steroid tablets regularly for more than 3 months?		
2	<i>Do you currently have Cancer of any kind? (If NO, go to Question 3)</i>		
2a	Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck?		
2b	Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)?		
3	<i>Do you have a heart or Cardiovascular Condition? This includes Coronary Heart Disease, Heart Failure, Diagnosed Abnormality or Heart Rhythm (If NO, go to Question 4)</i>		
3a	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)		
3b	Do you have an irregular heartbeat that requires medical management? (e.g. atrial fibrillation, premature ventricular contraction)		
3c	Do you have chronic heart failure?		
3d	Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity or exercise in the last 3 months?		
4	<i>Do you have High Blood Pressure? (If NO, go to Question 5)</i>		
4a	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)		
4b	Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer Yes if you do not know your resting blood pressure)		
5	<i>Do you have any Metabolic Conditions? This includes Type 1 and 2 Diabetes, Pre-Diabetes (If NO, go to Question 6)</i>		
5a	Do you often have difficulty controlling your blood sugar levels with foods, medications or other physician-prescribed therapies?		
5b	Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness.		
5c	Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, OR the sensation in your toes and feet?		
5d	Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)?		
5e	Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise soon?		
6	<i>Do you have any Mental Health Problems or Learning Difficulties? This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome (If NO, go to Question 7)</i>		
6a	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)		

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NO	QUESTIONS	YES	NO
6b	Do you have Down Syndrome AND back problems affecting nerves or muscles?		
7	Do you have a Respiratory Disease? This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure (If NO, go to Question 8)		
7a	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)		
7b	Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?		
7c	If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?		
7d	Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?		
8	Do you have a Spinal Cord Injury? This includes Tetraplegia and Paraplegia (If NO, go to Question 9)		
8a	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)		
8b	Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?		
8c	Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?		
9	Have you had a Stroke? This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event (If NO, go to Question 10)		
9a	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)		
9b	Do you have any impairment in walking or mobility?		
9c	Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?		
10	Do you have any other medical condition not listed above or do you have two or more medical conditions? (If NO, go to the declaration to read on the recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION).		
10a	Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months OR have you had a diagnosed concussion within the last 12 months?		
10b	Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?		
10c	Do you currently live with two or more medical conditions? (PLEASE LIST YOUR MEDICAL CONDITION(S) BELOW AND ANY RELATED MEDICATIONS THAT YOU TAKE)		

DECLARATION			
<p>If you have answered YES to any further screening questions about your medical conditions and there are at least 3 or more issues highlighted, it would be very necessary for you to be referred to your GP before you start in any Physical Activity or Exercise for advice, please take this form as well as PAR-Q Form to your local GP with you to gain clearance to participate in exercise as seen below for GP to sign, can be also either Practice Manager or Nurse as an alternative to sign – this may be at an additional cost for you to get approval as it's not our responsibility. If there are at least less than 3 issues highlighted, we can sign on behalf of GP Clearance for you to commence Physical Activity or Exercise at under your own risk for participation. If you or the GP are unsure of this declaration form to sign, please contact us directly from page 1 of details provided. If you have answered NO on the PAR-MEDX Form for further screening about your medical conditions that there are no issues, you would be able to take part in physical activity or exercise sessions without needing a GP approval signature, but please ensure that you begin slowly, warm up appropriately and progress slowly.</p> <p>Full Terms and Conditions can be found on our website for more information as below: www.breakingrecordsfitness.co.uk/terms-and-conditions</p>			

NAME		SIGNATURE		DATE	
GP NAME FOR CLEARANCE*		SIGNATURE		DATE	

*GP use only - please sign if the participant is cleared to do exercise and physical activity. If they are not, please terminate this form immediately