

# VO<sub>2</sub> MAX AND SUB-MAX METABOLIC TESTING MEDICAL HISTORY QUESTIONNAIRE

**\*Required before exercise test can be scheduled!!\***

Please complete and return the following forms to Fitness Wave Nor Cal as soon as possible in order to expedite the scheduling of your exercise test. The VO<sub>2</sub> assessment will determine your maximal aerobic capacity by scientifically measuring the rate at which oxygen can be distributed and utilized by the body during physical activity. A testing technician will discuss your results and personalized training plans will be outlined.

## PERSONAL INFORMATION

Gender: [ ] Male [ ] Female Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
Day Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Evening Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

## MEDICATIONS

List any prescribed medications you are currently taking and reason for taking each medication:

\_\_\_\_\_

List any over the counter medications you are currently taking including herbal, supplements and NSAIDS such as Advil, Motrin, Tylenol, etc.:

\_\_\_\_\_

## EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Day Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Evening Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_  
Primary Care Provider: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

## ACSM CORONARY ARTERY DISEASE RISK FACTORS

**KNOWN DISEASES** Do you have any of the following? Please elaborate on any "yes" answers below.

Category	Diseases	Yes	No
Cardiovascular	• Cardiac, peripheral vascular, or cerebrovascular disease	____	____
Pulmonary	• Chronic obstructive pulmonary disease, asthma, interstitial lung disease, cystic fibrosis	____	____
Metabolic	• Diabetes mellitus (type I or II), thyroid disorders, renal or liver disease	____	____

Comments: \_\_\_\_\_

**SIGNS AND SYMPTOMS** Do you experience any of the following? Please elaborate on any "yes" answers below.

	Yes	No
• Have you experienced unusual pain or discomfort in your chest (pain due to blockage in coronary arteries of the heart)?	____	____
• Have you experienced unusual shortness of breath during moderate exercise (such as climbing stairs)?	____	____
• Have you had any problems with dizziness or fainting?	____	____
• When you stand up, or sometimes during the night, do you have difficulty breathing?	____	____
• Do you suffer from swelling of the ankles (ankle edema)?	____	____
• Have you experienced a rapid throbbing or fluttering of the heart?	____	____
• Have you experienced severe pain in your leg muscles during walking?	____	____
• Has your doctor told you that you have a heart murmur?	____	____
• Have you felt unusual fatigue or shortness of breath with usual activities?	____	____

Comments: \_\_\_\_\_

**PLEASE CONTINUE ON TO THE FOLLOWING PAGE AND ANSWER ALL QUESTIONS**

**RISK FACTORS** To the best of your ability, check the appropriate yes/no box for each of the following questions.

Risk Factor	Defining Criteria	Yes	No
Family History	<ul style="list-style-type: none"> <li>Has your father or brother had a heart attack, stroke, or died suddenly of heart disease before the age of 55?</li> <li>Has your mother or sister had a heart attack, stroke, or died suddenly of heart disease before the age of 65?</li> </ul>	___	___
Cigarette Smoking	<ul style="list-style-type: none"> <li>Are you currently a cigarette smoker or have you quit within the past 6 months?</li> </ul>	___	___
Sedentary lifestyle	<ul style="list-style-type: none"> <li>Are you sedentary (i.e. not participating in at least 30 minutes of moderate intensity physical activity on at least three days of the week for at least three months)?</li> </ul>	___	___
Obesity	<ul style="list-style-type: none"> <li>Is your <b>BMI</b> of <math>&gt; 30 \text{ kg/m}^2</math>, <b>OR</b></li> <li>Is your Waist girth <math>&gt; 40</math> in for men; <math>&gt; 35</math> in for women <b>OR</b></li> <li>Is your Waist/Hip ratio: <math>\geq 0.95</math> for men and <math>\geq 0.86</math> for women?</li> </ul>	___	___
Hypertension (high blood pressure)	<ul style="list-style-type: none"> <li>Is your systolic blood pressure over 140 or diastolic blood pressure over 90 mm Hg?</li> <li>Are you on medication to control your blood pressure?</li> </ul>	___	___
Dyslipidemia	<ul style="list-style-type: none"> <li>Is your <b>LDL cholesterol</b> level above 130 mg/dl (<math>3.37 \text{ mmol-L}^{-1}</math>) <b>OR</b></li> <li>Is your <b>HDL cholesterol</b> level below 40 mg/dl (<math>1.04 \text{ mmol-L}^{-1}</math>) <b>OR</b></li> <li>Is your <b>Total Serum Cholesterol</b> above 200 mg/dl (<math>5.18 \text{ mmol-L}^{-1}</math>) <b>OR</b></li> <li>Are you on lipid-lowering medication?</li> </ul>	___	___
Pre-diabetes	<ul style="list-style-type: none"> <li>Have you had fasting blood glucose measurements of <math>\geq 100</math> mg/dL confirmed on at least 2 separate occasions?</li> </ul>	___	___

**MUSCULOSKELETAL**, Please elaborate on any yes answers in the comments section below.

<ul style="list-style-type: none"> <li>Do you have any current musculoskeletal limitations that may impair your ability to perform maximal exercise (back pain; swollen, stiff, or painful joints; arthritis; fibromyalgia, etc.)?</li> </ul>	Yes ___	No ___
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Comments: \_\_\_\_\_

**OTHER**

Please list and explain any other medical problems that you consider important for us to know:

\_\_\_\_\_

\_\_\_\_\_

**STAFF USE ONLY**

Resting: HR: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_

Risk Stratification (circle):      Low Risk      Moderate Risk      High Risk

Signed Forms received:      \_\_\_ Informed Consent/ Acknowledgment of Risk

\_\_\_ Cleared for maximal exercise

\_\_\_ Cleared for sub-maximal exercise (70% HRR **OR** 85% Age pred. HR<sub>max</sub>)

Staff signature: \_\_\_\_\_

Date: \_\_\_\_\_

**INFORMED CONSENT FOR EXERCISE TESTING: (READ CAREFULLY BEFORE SIGNING!)**

**1. Purpose and Explanation of the Test**

You will perform an exercise test on a cycle ergometer or another similar device. The exercise intensity will begin at a low level and will be advanced in stages depending on your fitness level. We may stop the test at any time because of signs of fatigue or changes in your heart rate, blood pressure, or symptoms you may experience. It is important for you to realize that you may stop when you wish because of feelings of fatigue or any other discomfort.

**2. Attendant Risks and Discomforts**

There exists the possibility of certain changes occurring during the test. These include abnormal blood pressure, fainting, irregular, fast or slow heart rhythm, and in rare instances, heart attack, stroke, or death. Every effort will be made to minimize these risks by evaluation of preliminary information relating to your health and fitness and by careful observations during testing. Emergency equipment and trained personnel are available to deal with unusual situations that may arise.

**3. Responsibilities of the Participant**

Information you possess about your health status or previous experiences of heart-related symptoms (such as shortness of breath with low -level activity, pain, pressure, tightness, heaviness in the chest, neck, jaw, back and/or arms) with physical effort may affect the safety of your exercise test. Prompt reporting of these and any other unusual feelings with effort during the exercise test itself are of great importance. You are responsible for fully disclosing your medical history, as well as symptoms that may occur during the test. You are also expected to report all medications (including non-prescription) taken recently and, in particular, those taken the day of testing, to the staff.

**4. Benefits to be Expected**

The results obtained from the exercise test will determine your maximal aerobic capacity by scientifically measuring the rate at which oxygen can be distributed and utilized by the body during physical activity. A testing technician will discuss your results and personalized heart rate training zones will be defined. Fitness Wave Nor Cal's fitness testing staff are not medical doctors and are not qualified to diagnose a participant's illness or state of disease.

**5. Inquires**

Any questions about the procedures used in the exercise test or the results of our test are encouraged. If you have any concerns or questions, please ask us for further explanations.

**6. Use of Medical Records**

The information that is obtained during testing will be treated as privileged and confidential. It will not be released or revealed to any person without your approval.

**7. Eligibility**

Only individuals determined to be "low risk" based on ACSM's risk stratification guidelines may perform maximal testing. Individuals determined to be "moderate risk" may only participate in sub-maximal testing.

**8. Acknowledgement and Consent**

I expressly acknowledge that the exercise test is done for information purposes and not for the purpose of diagnosing or treating injuries or illnesses, and that the exercise test and any results does not in any way declare whether I am fit to utilize the fitness center. I hereby consent to voluntarily engage in an exercise test to determine my exercise capacity and state of cardiovascular health. My permission to perform this exercise test is given voluntarily. I understand that I am free to stop the test at any point, if I so desire.

**BY MY SIGNATURE BELOW I UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.**

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(If under 18 years, parent or guardian signature is required)

**OVER**

**ACKNOWLEDGMENT OF RISK AND HOLD HARMLESS AGREEMENT: (READ CAREFULLY BEFORE SIGNING!)**

1. I hereby acknowledge that I have voluntarily chosen to participate in the VO2 max and sub-max metabolic testing (exercise testing) through Fitness Wave Nor Cal.
2. I am aware that Fitness Wave Nor Cal's fitness testing lab staff are not medical doctors and are not qualified to determine a participant's physical capability to engage in strenuous exercise.
3. The information given on the medical history questionnaire is correct to the best of my knowledge. I understand that absence of the physical problems listed on this form does not necessarily guarantee that I am in satisfactory health to participate in an exercise test.
4. **Acknowledgment of Risk.** I understand and acknowledge the risks involved in participating in exercise testing at Fitness Wave Nor Cal's fitness testing lab, including, but not limited to, the risks involved in utilizing equipment or participating in any exercise or fitness activity. I have been informed that these risks, though remote include abnormal blood pressure, fainting, disorders of heart rhythm, stroke, and very rare instances of heart attack or even death. While I have been assured that every effort will be made to minimize these occurrences by precautions taken during testing. I have also been informed that emergency equipment (First Aid Kit/AED) and trained personnel are available to deal with these unusual situations should they occur, I understand that the fitness testing lab does not employ medical professionals.
5. **Assumption of Risks.** I understand that I am responsible for researching and evaluating the risks that I may face and am responsible for my actions. I also understand that if I have any doubts of my physical or mental condition, I am responsible for discussing the activities and risks involved in the exercise test with my physician. Any activities that I may take part in, whether as a component of the exercise test or separate from it, will be considered to have been undertaken with my approval and understanding of any and all risks involved.

I agree to expressly assume and accept any and all risks associated with the exercise test, including but not limited to, travel to/from the testing lab facilities and limited availability of medical aid. By voluntarily participating in exercise testing with the knowledge of the risks involved, I hereby agree to accept any and all inherent risks of property damage, bodily injury or death.

6. **Release, Indemnification and Hold Harmless.** In consideration for being allowed to participate in the VO2 max and sub-max metabolic testing (exercise test) offered in the Fitness Wave Nor Cal's fitness testing lab and to the fullest extent permitted by law, I agree to indemnify, defend and hold harmless Fitness Wave Nor Cal, its trustees, officers, employees, volunteers, agents and assigns from and against all claims arising out of or resulting from my participation in the exercise test, except for claims arising out of the sole negligence or willful misconduct of Fitness Wave Nor Cal, its trustees, officers, employees, volunteers, agents and assigns.. "Claim" as used in this agreement means any financial loss, claim, suit, action, damage or expense, including but not limited to attorney's fees, attributable to bodily injury, sickness, disease or death, or injury to or destruction of tangible property including resulting loss of use. In addition, I hereby voluntarily **release, forever discharge and agree not to sue** Fitness Wave Nor Cal, its trustees, officers, employees, volunteers, agents and assigns from any and all claims, both present and future, that may be made by me, my family, estate, heirs or assigns. I further understand that this acknowledgment of risk and hold harmless is intended to be as broad and inclusive as permitted by the laws of the State of California, or any other applicable laws, and that if any portion hereof is held invalid, I agree that the remainder shall, notwithstanding, continue in full legal force and effect.

**I HAVE READ AND FULLY UNDERSTAND THIS ACKNOWLEDGMENT OF RISK AND HOLD HARMLESS AGREEMENT.**

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(If under 18 years, parent or guardian signature is required)

**Thank you for taking the time to complete and return this form prior to your test!**