HOSPITAL FOR SPECIAL SURGERY

Sports Rehabilitation and Performance Center
Bike Fitting Services
PAR-Q

Date: _____

MR #

Name:		**Date Of Birth:**			
Gender:	Male Female	**Age:**			
MD/ PCP:		**MD Phone:**			
Emergency Contact:		**Relationship:**		**Phone#**	

History:

1. **How would you describe your current level of physical activity?**

- ☐ **Inactive-** just activity of daily living
- ☐ **Light -** some walking, gardening, occasional recreational activity
- ☐ **Moderate** - regular (3x wk) moderate activity, occ. Weekend sports
- ☐ **Heavy** - regular (4-6x wk) vigorous activity and/or sports
- ☐ **Intense** - Competitive vigorous sports training

2. **Do you ever have:**

(during exertion or other times)

- ☐ Discomfort/pressure in your chest, neck, jaw or arms
- ☐ Lightheadedness, dizziness or fainting
- ☐ Shortness of breath not associated with vigorous activity
- ☐ Rapid heart beats

Medical History

3. **Do you Smoke?** ☐ Yes ☐ No If YES, How many years ____ If you quit, when? _____

4. **Have you ever been told by a doctor that you have:**

High Blood Pressure ☐ Yes ☐ No ☐ Unsure **Diabetes** ☐ Yes ☐ No ☐ Unsure

High Cholesterol ☐ Yes ☐ No ☐ Unsure **Heart or Lung problems** ☐ Yes ☐ No ☐ Unsure

5. **Do you have a bone, joint, or muscle problem that could be made worse with exercise?** ☐ Yes ☐ No

Please Describe_____

6. **Are you pregnant?** ☐ Yes ☐ No

Family History

7. Has your father, grandfather or brother had a heart attack or sudden death before the age of 55?

☐ **Yes** ☐ **No**

8. Has your mother, grandmother or sister had a heart attack or sudden death before the age of 65?

☐ **Yes** ☐ **No**

9. Please list all medications you currently take.

1. _____ 2. _____ 3._____

10. Please list any other medical problems/health concerns.

1._____ 2._____ 3. _____

Signature: _____ Date: _____