Department of Veterans Affairs

EmployeeHealthPromotion Disease Prevention

Sample Personal Fitness Certification

Employee/Volunteer Name_____ Age_____
Dept/Clinic_____ Phone (W)_____
Date of Birth_____ Healthcare Provider_____
Provider's Phone_____

HEALTH QUESTIONNAIRE

Circle Answer:

1. Has your health care provider ever said you have heart trouble? YES NO
2. Do you ever experience pains in your chest? YES NO
3. Do you have spells of dizziness or feelings of fainting? YES NO
4. Has your health care provider ever said your blood pressure was high? YES NO
5. Has your health care provider ever told you that you have a joint or bone problem, such as arthritis, that may be aggravated by exercise, or made worse? YES NO
6. Is there any physical reason not mentioned here that would prevent you from following an active exercise program? YES NO
7. Are you over 40 years old and not accustomed to vigorous exercise? YES NO
8. Are you currently taking any medications? YES NO
   a. If yes, please list which ones_____
   _____
   b. Taken for which reason_____
   _____

If you answered YES to any questions 1 through 7 or currently take any insulin, anti-seizure, cardiac, or anticoagulant medication, you must seek approval from your healthcare provider prior to participating in (location) VA exercise programs.

Healthcare Provider Signature_____

Comments:_____
_____

The above questions have been answered truthfully and to the best of my knowledge. I am not withholding any information regarding my health status that would place me at increased risk of injury or cardiovascular problems by participating in this exercise program.

Signed_____ Date_____

RETURN TO EMPLOYEE HEALTH WHEN COMPLETE

Center for Engineering & Occupational Safety and Health, and
Occupational Health Strategic Healthcare Group, Office of Public Health (10P3)
Veterans Health Administration, Department of Veterans Affairs
www.publichealth.va.gov/employeehealth