

BROOKHAVEN NATIONAL LABORATORY

**BERA SPORTS FITNESS CLEARANCE
QUESTIONNAIRE**

Name: _____ BNL Life Number: _____ Work Ext: _____

Please list **ALL** sports you will be signing up for with BERA in the next year:

Note: You will have to be seen in person at OMC if you have not had an OMC Physical for > 2 years.

HAVE YOU EVER BEEN TOLD THAT YOU HAVE OF ANY OF THE FOLLOWING?

Heart/Vascular Disease:

Please Specify:

- Yes No *Angina, chest discomfort or pain (at rest or exertion)
- Yes No *Coronary angioplasty or cardiac surgery
- Yes No *Heart disease, heart attack
- Yes No *Heart murmur/ heart valve disease
- Yes No *Peripheral vascular disease / stroke
- Yes No *Has your doctor ever said that you have a heart condition **and** that you should only do physical activity recommended by a doctor?

***Doctor's note required if yes to any of the above conditions.**

- Yes No High blood pressure/hypertension
- Yes No Shortness of breath at rest or with mild exertion
- Yes No Dizziness or fainting; Loss of balance
- Yes No Palpitations
- Yes No Have you ever felt dizzy or passed out during exercise?

Please Specify:

- Yes No Diabetes
- Yes No Thyroid or other endocrine problem
- Yes No Anemia
- Yes No Hernia
- Yes No Seizures/epilepsy
- Yes No Asthma
- Yes No Emphysema or chronic obstructive lung disease (COPD)
- Yes No Cancer
- Yes No **WOMEN:** are you currently pregnant?

Other (please indicate) _____

Please check if you have any of the following conditions.

- Yes No Are you on restricted duty?
- Yes No A history of or have current Musculoskeletal/Joint problems (e.g. arthritis, back, shoulder, knees,):
- Yes No Are you currently receiving Wound care/ PT/Chiropractic treatment?
- Yes No Major surgery or hospitalization within the past 6 months. Please explain: _____

Yes No Medications, list those that you are taking: _____

Yes No Do you have any other medical conditions, serious medical illness, or physical limitations that may affect participation in BERA Sports? *Please indicate:* _____

Yes No Have you ever been restricted from participation in sports due to the above?

Personal Health History

Do you currently smoke? Yes No If yes, how many years have you been smoking? _____

Did you ever smoke? Yes No If yes, how long and when did you quit? Years: _____ Quit year: _____

Exercise: Estimate amount of exercise time hours/day _____

I verify that I have answered all questions truthfully and to the best of my knowledge. If I have a change in my health status during the course of my physical activity program, I will notify the Occupational Medical Clinic immediately and provide information as requested.

Signed: _____ Date: _____

After completing & signing, mail form in a privacy envelop to OMC, Building 490, ATTN: BERA Sports Clearance

OMC use only

| Reviewed by: | Signature | Date |
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