NORTH YORKSHIRE MEDICALS

Cardiovascular/musculoskeletal screening tool

Forename(s): Surname:

Date of birth: Gender: F M

Address:

Please answer all of the following questions accurately.

Have you ever suffered from any of the following?

Yes	No	
◯	◯	Chest pain
◯	◯	Palpitations
◯	◯	Joint pain or swelling
◯	◯	Recurrent pain in your back

Have you ever undergone any of the following?

Yes	No	
◯	◯	Coronary artery bypass
◯	◯	Coronary angiogram
◯	◯	Pacemaker insertion
◯	◯	Implanted cardiac defibrillator
◯	◯	Joint replacement or other joint surgery
◯	◯	Are you regularly taking any medication? If yes, please list:

Have you ever been diagnosed with any of the following?

Yes	No	
◯	◯	Coronary artery disease
◯	◯	Angina
◯	◯	Heart attack/myocardial infarction
◯	◯	Aortic aneurysm
◯	◯	Heart failure
◯	◯	High blood pressure
◯	◯	Cardiac arrhythmia
◯	◯	Cardiomyopathy
◯	◯	Osteoarthritis
◯	◯	Rheumatoid arthritis
◯	◯	Other joint or bone disease

Do you have any other concerns about your ability to carry out a physical fitness test?

Yes	No
◯	◯

Signature: Date:

(Please type name above)

NOTE: Positive answers to any of the above questions may require referral to a physician for further consideration and investigation prior to clearance to participate in the aerobic capacity assessment.

SEND FORM

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