

Santa Ana Health Screening Questionnaire

All information will be kept confidential

Name: _____ Phone # (H) _____ (W) _____
 Address: _____ Male/Female _____ Date of Birth _____ Age: _____
 Emergency Contact: _____ Day ph # _____ Eve # _____
 Doctor's name: _____ Dr's ph# _____

Where do you go for your health care? Santa Ana Clinic Other: _____
 Are you (Circle all that apply): Tribal member Employee Native American visitor

**Do you have or have you had any of the following health conditions?
 (mark all that apply)**

HEALTH HISTORY

- a heart attack
- heart surgery
- stroke
- pacemaker-implantable cardiac
- other heart conditions

HEALTH STATUS

- Diabetes:
If yes, when were you diagnosed? _____
- Asthma or other lung disease
- Currently Pregnant

SYMPTOMS

- You experience chest discomfort with exertion
- You experience unreasonable breathlessness
- You experience dizziness, fainting, or blackouts
- You have burning or cramping sensation in you lower legs when walking a short distances

CARDIOVASCULAR RISK FACTORS

- You are a man older than 45 years
- You are a woman older than 55 years,
- You are a woman who has had a hysterectomy **OR** are postmenopausal
- Pre-diabetes
- You smoke, or quit smoking within the previous 6 months
- Your doctor has told you that you have high blood pressure ♥
- You take blood pressure medication♥
- Your doctor has told you that you have high cholesterol
- You have a close blood relative who had a heart attack or heart surgery before age 55 (father or brother) or age 65 (mother or sister)

OTHER HEALTH ISSUES

- Given birth in the last 8 weeks: If yes, are you cleared for exercise? ____Yes ____No
- Significant recent changes in health status that has not been evaluated by a physician?
If yes, please explain: _____

I do not have any of the above Health conditions or Risk factors

If you answered yes to diabetes, do you have?

- Numbness or loss of feeling in your hands or feet
- Vision problem
- Diabetic kidney problems
- Have you ever had symptoms of high/low blood sugar?

If yes to any of the above explain the best you can: _____

List medications: I am not currently taking any medication.

Name _____	Purpose _____
_____	Purpose _____
_____	Purpose _____
_____	Purpose _____

WAIVER OF LIABILITY

I have read the questions on this questionnaire, understand them, and have answered them to the best of my knowledge. I understand that, depending on my health and fitness, participation in an exercise program may involve some risks to my health, including injury, abnormal blood pressure response, fainting, dizziness, irregular heart rhythm, and in rare instances, heart attack, stroke or even death. I understand that a medical clearance may be required prior to my participation. I understand that I should report any unusual symptoms that I experience during or after exercise, and that I should update my health history questionnaire should I become aware of a change in my health status. Any questions that I had were answered to my satisfaction. I hereby release the Pueblo of Santa Ana and it's tribal administration, employees, agents, or volunteer staff from any liability for any injuries, which may arise as a result of my participation in an exercise program.

Participant Signature _____ **Print name** _____

Date: _____

Fitness Staff only Interview Questions & Measurements

- Do you have muscle and/or joint problems that limit your physical activity? ___Yes ___No

If yes explain: _____

If yes, have them complete a Pain Assessment

Is Medical Clearance indicated by the Pain Assessment? ___Yes ___No

Below enter how the participant wants to be contacted: # 1 Kathy contacts, # 2. Participant contacts, #3 not interested

- Do you know your cholesterol level? ___Yes ___No
If no, would you like to participate in a cholesterol screening? ___Yes ___No Contact # _____
- Have you ever had diabetes screening? ___Yes ___No
If no, would you like to participate in a diabetes screening? ___Yes ___No Contact # _____
- If diabetic we recommend that you attend an education session on foot care and blood sugar monitoring with exercise. Are you interested? ___Yes ___No ___ Contact # _____

Blood Pressure: _____ If results is > 140/90, repeat 2 additional separate dates:

1. Date _____ Results _____ 2. Date _____ Results _____

Weight (Optional): _____ **Height:** _____

Orientation Date Completed: Cardio _____ Strength training _____

Staff Coordinator Only

BP results copied for participant to take to MD

Medical Clearance sent to MD

Exercise Clearance received

Contact info given to participant for cholesterol/DM screen

Cholesterol results received & risk re-evaluated

Clinic Referral _____ Walk in _____

NA Yes Initials _____ Date _____

Cleared to Exercise Yes No **Staff Initials** _____ **Date** _____