Pre and Post Natal Health Questionnaire

Name:
Address:

Tel:
Occupation:
Date of birth:
Doctors name and address:

Midwife contact:

Emergency contact:

Accidents: Whilst every effort is made to protect my health and safety I agree that all exercise undertaken by me is at my sole risk and in consultation with my health care team.

Signature: Date:

General Health Related Questions

1: Have you ever had or has your doctor ever diagnosed you as having heart trouble or coronary disease? YES/NO

2: Is there a history of heart problems or coronary disease in your family? YES/NO

3: Do you have pains in your chest? YES/NO

4: Do you have a history of high blood pressure? YES/NO

5: Do you suffer from diabetes? YES/NO

6: Do you suffer from asthma/bronchitis? YES/NO

7: Do you smoke cigarettes? YES/NO

8: Do you suffer from epilepsy of fainting spells? YES/NO

9: Has your doctor ever said you have high cholesterol? YES/NO

10: Do you suffer with joint problems or back pain? YES/NO

Additional comments: