

# Bere Alston Trekkers (BATs)

## Par Q Form (memberships 2020)



Name: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

In Case of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Doctor: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you currently under a doctor's care: Yes  No

If yes, explain: \_\_\_\_\_

When was the last time you had a physical examination? \_\_\_\_\_

Have you ever had an exercise stress test: Yes  No  Don't Know

If yes, were the results: Normal  Abnormal

Do you take any medications on a regular basis? Yes  No

If yes, please list medications and reasons for taking: \_\_\_\_\_

Have you been recently hospitalized? Yes  No

If yes, explain: \_\_\_\_\_

Do you smoke? Yes  No

Are you pregnant? Yes  No

Do you drink alcohol more than three times/week? Yes  No

Is your stress level high? Yes  No

Are you moderately active on most days of the week? Yes  No

Do you have:

High blood pressure? Yes  No

High cholesterol? Yes  No

Diabetes? Yes  No

Epilepsy? Yes  No

Asthma? Yes  No

If yes, please list medications and reasons for taking: \_\_\_\_\_

Have you had:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| A heart attack?                                    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| A stroke?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| High blood pressure?                               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| High cholesterol?                                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Known heart disease?                               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Rheumatic heart disease?                           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| A heart murmur?                                    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Chest pain with exertion?                          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Irregular heart beat or palpitations?              | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Lightheadedness or do you faint?                   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Unusual shortness of breath?                       | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Cramping pains in legs or feet?                    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Emphysema?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Other metabolic disorders (thyroid, kidney, etc.)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Back pain: upper, middle, lower?                   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Other joint pain (explain below)?                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Muscle pain or an injury (explain below)?          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

To the best of my knowledge, the above information is true.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Additional information (if applicable):