Please provide the following information as accurately and completely as possible so that we may assess whether you are a “suitable candidate” to participate in the Yoga Class.

**Known Cardiovascular, Pulmonary or Metabolic Disease**
Do you have a personal history of any of the following?

- [ ] Yes  [ ] No Myocardial infarction (“heart attack”)
- [ ] Yes  [ ] No Stroke or ischemic attack (“mini-stroke”)
- [ ] Yes  [ ] No Other cardiovascular disease/disorder (aneurysm, etc.)
- [ ] Yes  [ ] No Asthma or chronic obstructive pulmonary disease (COPD, etc.)
- [ ] Yes  [ ] No Diabetes (insulin dependent, non-insulin dependent, etc.)
- [ ] Yes  [ ] No Other

**Other Information Concerning Personal Health History**
Do you have a personal history of any of the following?

- [ ] Yes  [ ] No Diagnosed back/neck disorder
- [ ] Yes  [ ] No Currently under doctor’s care for back/neck disorder
- [ ] Yes  [ ] No Been to doctor within the past year for back pain
- [ ] Yes  [ ] No Back pain
- [ ] Yes  [ ] No Neck pain
- [ ] Yes  [ ] No Joint surgery, joint pain or joint swelling
- [ ] Yes  [ ] No Osteoporosis (“low bone density”)
- [ ] Yes  [ ] No Occasional significant numbness/weakness
- [ ] Yes  [ ] No Balance or gait problems
- [ ] Yes  [ ] No Sit for 30 hours or more per week during work

**Physical Activity Readiness Questionnaire (PAR-Q)**
- [ ] Yes  [ ] No Has your doctor ever said you have a heart condition and should only do physical activity recommended by a doctor?
- [ ] Yes  [ ] No Do you feel pain in your chest when you do physical activity?
- [ ] Yes  [ ] No In the past month, have you had chest pain when you were not physically active?
- [ ] Yes  [ ] No Do you lose your balance because of dizziness or do you ever lose consciousness?
- [ ] Yes  [ ] No Do you have a bone or joint problem that could be made worse by a change in your physical activity?
- [ ] Yes  [ ] No Is your doctor currently prescribing drugs for your blood pressure or heart condition?
- [ ] Yes  [ ] No Do you know of any other reason why you should not do physical activity?

*Comment:* ________________________________

*Comment:* ________________________________
### Drugs/Medications

Please list any prescription or over the counter (OTC) drugs/medications you are currently taking.

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### Doctor / Health Plan Information  
(Must be completed)

- **Name / Group**: ____________________________
- **Phone / Fax**: ____________________________
- **Address**: ____________________________

### In Case of Emergency  
(Must be completed)

- **Name**: ____________________________
- **Phone**: ____________________________

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**Upon completion of this form, I declare and understand the following:**

Initial

— I have completed this health history to the best of my recollection and have not knowingly withheld any information concerning my health history.

_________________________  __________________
Signature                  Date

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*Please return this form when completed and signed to:*

**Employee Wellness Program**

**KHS-121**