Initial pre-exercise and protocol assessment (To be completed by the athlete and returned in person or e-mail)

Planned protocol: A 20 minute British Cycling approved warm up and 20 minute Wattbike test to exhaustion OR 3 minute Wattbike test.

Athlete name:

Date of birth:

Next of kin:

Address:

Mobile number:

Home number:

Best Contact number:

General Practitioner:

Address:

Contact number:

		YES	NO
.A.	Do you wear spectacles / hearing aids / contact lenses?		

.B.	Cardiac History: Do you suffer with or have had any of the following?	YES	NO
	High Blood Pressure (Hypertension)		
	Chest Pain / Angina		
	Heart Attack		
	Palpitations / Irregular heart beat		
	Heart Murmur / Rheumatic Fever / Endocarditis		
	Pace-maker		
	Cardiac Surgery		
	Pitting Oedema (swollen ankles) or DVT history		

.C.	Respiratory History: Do you suffer with or have had any of the following?	YES	NO
	Asthma		
	Emphysema or Chronic Bronchitis		
	Have you ever had TB (Tuberculosis)		
	COPD (Chronic Obstructive Pulmonary Disease)		
	Do you smoke? If yes, how many cigarettes a day? (Please state)		
	Have you smoked within the last 5 years?		
	Have you ever been told that you have Obstructive Sleep Apnoea?		
	Shortness of breath at rest or when exercising?		
	Difficulties lying flat?		
	Previous Neck, Throat, Lung surgery		
	Serious Musculoskeletal disorders		
	Respiratory infections (tendancy for colds to migrate to chest requiring antibiotics usually)		

.D.	Gastrointestinal History: Do you suffer with or have had any of the following?	YES	NO
	Do you have any loose, capped, crowned or false teeth?		
	Do you suffer with Heartburn / Indigestion?		
	IBS (Irritable Bowel Syndrome)		
	Crohns Disease		

.E.	General: Do you suffer with or have had any of the following?	YES	NO
	Joint or Arthritis problems		
	Restricted Neck or Jaw movements		
	Do you or have you ever suffered from Depression, Anxiety or any Psychiatric illness?		
	Thyroid problems (such as over or under-active Thyroid)		
	Stroke (CVA) or Mini Stroke (TIA)		
	Diabetes – Diet / Tablet / Insulin controlled (Please highlight)		
	Kidney, Bladder or Urinary problems		
	Excessive Bleeding / Bruising / Clotting Disorder		
	Bloods Clots / Embolism / Deep Vein Thrombosis		
	Anaemia		
	Muscle Disease / Progressive weakness		
	Epilepsy / Fits		
	Have you or a close relative ever been diagnosed with CJD (Creutzfeldt Jacob Disease)?		
	Have you ever had MRSA (Methicillin Resistant Staphylococcus Aureus)		
	How many units of alcohol do you drink within a week? 0-1		

.G.	Medication History	YES	NO
	Have you ever been treated with Anti-coagulant / Anti-platelet medication? i.e. Aspirin / Clopidogrel / Warfarin / Heparin		
	Have you or are you currently taking Steroids?		
	Have you or do you currently take Recreational Drugs?		
	Please provide details of all current Medication (Including Herbal Medicine) Drug name Dose Frequency		
	Do you suffer from Allergies / Hay Fever or ever had any reactions to food / plasters / latex / animals? Please provide information including type of reaction.		

.H.	Surgical
	Please list any operations you have had and the year you had them.
	Do you have any special dietary requirements? If so please state.

I understand that the protocols and tests I am about to undertake are physically demanding and that as far as I am aware I am of sufficient fitness to complete them. I have answered the above questions fully and honestly and have provided a letter from my medical professional if I am unsure of the impact of a positive answer any of the above questions on undertaking strenuous activity. As regarding the tests I may perform today I understand that I may cease at any time.

Date Name Signature